SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

Filing at a Glance

Company: MONY Life Insurance Company of America

Product Name: Individual Life Insurance Application	SERFF Tr Num: ELAS-127186217	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49042
Sub-TOI: L08.000 Life - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Audrey Arnold, Samra Mekbeb, Sabrena Lallmohamed, Jillian Rios	Disposition Date: 06/14/2011
	Date Submitted: 06/10/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Life Insurance Applications	Status of Filing in Domicile: Not Filed
Project Number: AXA-Life-2011	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: We are preparing and submitting these filings simultaneously; and will submit this filing to our state of domicile, Arizona.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 06/14/2011
	State Status Changed: 06/14/2011
Deemer Date:	Created By: Audrey Arnold
Submitted By: Audrey Arnold	Corresponding Filing Tracking Number:

Filing Description:

MONY Life Insurance Company of America1290 Avenue of the AmericasNew York, NY 10104Telephone (212) 314-2922Facsimile (212) 707-7493john.finneran@axa-equitable.com
John R. FinneranAssistant Vice President

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

June 10, 2011

VIA SERFF
Mr. Jay Bradford
Insurance Commissioner
Arkansas Department of Insurance
1200 W. Third Street
Little Rock, AR 72201-1904

RE: MONY Life Insurance Company of America (MLOA)
NAIC No.: 968-78077 FEIN No.: 86-0222062
Form Nos.: AXA-Life-2011AR – Individual Life Insurance Application
AXA-Term-2011 – Term Life Insurance Questionnaire
AXA-ILLeg-2011 (PRF) – Variable Universal Life Insurance Questionnaire
AXA-LTC-2011 – Long-Term Care Services Rider Questionnaire
AXA-OWNR-2011 – Owner Questionnaire
AXA-FRN-2011 – Foreign Residence and Travel Information Questionnaire
AXA-MED-2011 – Medical Information Questionnaire
AXA-FIN-2011 – Financial Questionnaire
AXA-CTR-2011 – Children's Term Insurance Rider Questionnaire
AXA-SUB-2011 – Substance Usage Questionnaire
AXA-AVN-2011 – Aviation Questionnaire
AXA-AVC-2011 – Avocation Questionnaire
AXA-TCPO-2011 – Term Policy/Rider Conversion or Purchase Option Questionnaire
AXA-TIA-2011 – Temporary Insurance Agreement
AXA-TCONV-2011 – Term Conversion Application
SERFF Tracking No.¨ ELAS-127186217

Dear Commissioner Bradford:

We are filing for your approval, the above-referenced Individual Life Insurance Application forms; these are new forms and replace AMIGV-2009 (approved by the Department on October 22, 2008, SERFF Tracking No. ELAS-125849305, State Tracking Number 40557) and its supplements. The forms will be used in the general market for use with all of our individual life insurance products: Whole Life, Current Assumption Whole Life, Term Life, Survivorship Universal Life,

Joint Universal Life, Corporate Owned Life, Flexible Premium Universal Life, and Flexible Premium Variable Life, as well as with any future products that we may offer. We will file, as required, any future products for the Department's review and approval prior to use.

The above-referenced application forms require fewer signatures than our previous applications. Section D contains the forms that require signatures, as well as a list of forms with check-off boxes indicating that the signatures apply to those sections. Fewer signatures will simplify the application process for the financial professionals and applicants. The Company's published underwriting guidelines are followed in this process.

Please note that a concurrent filing of the identical forms referenced above is being submitted for use with products issued by AXA Equitable Life Insurance Company (SERFF Tracking Number ELAS-127186216), therefore we request that one reviewer be assigned all submissions.

This new business individual life insurance application consists of the following sections:

Section A: Proposed Insured Information. This section will be completed for all products; it contains the Proposed Insured's personal, employment, financial, etc. information.

Section B: Product Information. This section is made up of separate forms, one for each type of insurance we currently offer. The applicant will complete only the form corresponding to the type of insurance for which he/she is applying.

Section C: Additional Underwriting Requirements. This section consists of additional underwriting questionnaires which the applicant will complete, based on the answers to the questions in Section A. For example, if the Proposed Insured indicates that he/she will be traveling outside of the United States in the near future, he/she will be instructed to complete the Foreign Travel and Residence Questionnaire.

Section D: Authorization/Agreement Signature Document. This section contains the Owner's and Proposed Insured's authorizations, agreements and signatures.

Form number AXA-Life-2011AR consists of Sections A and D.

Each questionnaire in Sections B and C have separate form numbers (as listed in the RE: section of this letter), as they will be filed as insert pages.

Form number AXA-TIA-2011 is our temporary insurance agreement and will be provided only when money is taken with the application.

Form number AXA-TCONV-2011, Term Conversion Application is a stand alone application (not part of AXA-Life-

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

2011AR) used in term conversion situations which do not require any underwriting.

I certify that form Nos. AXA-Life-2011AR, AXA-TCONV-2011, AXA-Term-2011, AXA-ILLeg-2011 (PRF), AXA-LTC-2011, AXA-OWNR-2011, AXA-FRN-2011, AXA-MED-2011, AXA-FIN-2011, AXA-CTR-2011, AXA-SUB-2011, AXA-AVN-2011, AXA-AVC-2011, AXA-TCPO-2011, and AXA-TIA-2011 achieve a Flesch Readability Score of 51.88, 51.88, 53.43, 51.12, 64.90, 63.41, 64.06, 56.63, 50.05, 53.76, 56.73, 53.34, 71.82, 62.35, and 50.62, respectively. Our signed certification of readability is enclosed.

We have enclosed our Statement of Variability.

I certify that, to the best of my knowledge and belief, we comply with all the requirements of Arkansas Rule and Regulation 33 regarding variable life insurance.

We are submitting the filing fee in the amount of $750.00 through EFT.

We request that the information contained in this letter and any attachments hereto be treated as confidential and be exempted from disclosure in accordance with the state's Freedom of Information law or other similar laws, and that we be notified prior to any proposed release of this information.

These forms are submitted in final printed format, subject to minor modification in paper size and stock, ink, logo, border, pagination, and adaptation to electronic printing or desktop publishing software.

If you have any questions or need additional information, please feel free to call me collect at (212) 314-2922.

Sincerely,

John R. Finneran
Assistant Vice President

Company and Contact

Filing Contact Information

Estella A. Devian, Vice President	estella.devian@axa-financial.com
1290 Avenue of the Americas, 14th Floor	212-314-2921 [Phone]
New York, NY 10104	212-707-7493 [FAX]

Filing Company Information

MONY Life Insurance Company of America	CoCode: 78077	State of Domicile: Arizona
1290 Avenue of the Americas, 14th Floor	Group Code: 968	Company Type: Insurance

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

Company

New York, NY 10104 Group Name: State ID Number:

(212) 314-2921 ext. [Phone] FEIN Number: 86-0222062

Filing Fees

Fee Required?	Yes
Fee Amount:	$750.00
Retaliatory?	No
Fee Explanation:	$50.00 per form for 15 forms.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MONY Life Insurance Company of America	$750.00	06/10/2011	48571822

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/14/2011	06/14/2011

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

Disposition

Disposition Date: 06/14/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Individual Life Insurance Application		Yes
Form	Term Life Insurance Questionnaire		Yes
Form	Variable Universal Life Insurance Questionnaire		Yes
Form	Long-Term Care Services		Yes
Form	Owner Questionnaire		Yes
Form	Foreign Residence and Travel Information Questionnaire		Yes
Form	Meidcal Information Questionnaire		Yes
Form	Financial Questionnaire		Yes
Form	Children's Term Insurance Rider Questionnaire		Yes
Form	Substance Usage Questionnaire		Yes
Form	Aviation Questionnaire		Yes
Form	Avocation Questionnaire		Yes
Form	Term Policy/Rider Conversion or Purchase Option Questionnaire		Yes
Form	Temporary Insurance Agreement		Yes
Form	Term Conversion Application		Yes

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

Form Schedule

Lead Form Number: AXA-Life-2011

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AXA-Life-2011AR	Application/ Enrollment Form	Individual Life Insurance Application	Initial		51.880	AXA-Life-2011AR.pdf
	AXA-Term-2011	Other	Term Life Insurance Questionnaire	Initial		53.430	AXA-Term-2011.pdf
	AXA-ILLeg-2011 (PRF)	Other	Variable Universal Life Insurance Questionnaire	Initial		51.120	AXA-ILLeg-2011 (PRF).pdf
	AXA-LTC-2011	Other	Long-Term Care Services	Initial		64.900	AXA-LTC-2011.pdf
	AXA-OWNR-2011	Other	Owner Questionnaire	Initial		63.410	AXA-OWNR-2011.pdf
	AXA-FRN-2011	Other	Foreign Residence and Travel Information Questionnaire	Initial		64.060	AXA-FRN-2011.pdf
	AXA-MED-2011	Other	Meidcal Information Questionnaire	Initial		56.630	AXA-MED-2011.pdf
	AXA-FIN-2011	Other	Financial Questionnaire	Initial		50.050	AXA-FIN-2011.pdf
	AXA-CTR-2011	Other	Children's Term Insurance Rider Questionnaire	Initial		53.760	AXA-CTR-2011.pdf
	AXA-SUB-2011	Other	Substance Usage Questionnaire	Initial		56.730	AXA-SUB-2011.pdf
	AXA-AVN-2011	Other	Aviation Questionnaire	Initial		53.340	AXA-AVN-2011.pdf
	AXA-AVC-2011	Other	Avocation Questionnaire	Initial		71.820	AXA-AVC-2011.pdf
	AXA-	Other	Term Policy/Rider	Initial		62.350	AXA-TCPO-

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

TCPO-2011		Conversion or Purchase Option Questionnaire			2011.pdf
AXA-TIA-2011	Other	Temporary Insurance Agreement	Initial	50.620	AXA-TIA-2011.pdf
AXA-TCONV-2011	Application/ Enrollment Form	Term Conversion Application	Initial	51.880	AXA-TCONV-2011.pdf

AXA EQUITABLE

[1290 Avenue of the Americas, New York, NY 10104]

(Select One)
☐ AXA Equitable Life Insurance Company
☐ MONY Life Insurance Company of America

Application for Individual Life Insurance-Part 1

"AXA Equitable" is the brand name of AXA Equitable Financial Services, LCC and its family of companies, including AXA Equitable Life Insurance Company and MONY Life Insurance Company of America.

SECTION A-PROPOSED INSURED INFORMATION

PROPOSED INSURED

Plan Name_____ Face Amount_____

1. Name First _____ Middle _____ Last _____
2. SSN_____ 3. Sex ☐ Male ☐ Female
4. Is the Proposed Insured the Owner? ☐Yes ☐No (If "No," complete Owner Questionnaire or see Survivorship Product Questionnaire if applicable)
5. Primary residential address_____ Bldg/Apt/Suite_____
   City/Municipality_____ County/Parish*_____ State _____ Zip _____
   ** County/Parish required only in AL, FL, GA, KY, LA, SC*
6. Are you a U.S. citizen? ☐ Yes ☐ No (If "No," complete Foreign Residence and Travel Questionnaire)
7a. Phone # _____ ☐Daytime ☐Cell ☐Evening b. Best time to call_____☐AM ☐PM
8. Date of birth_____ (mm/dd/yyyy) 9. Place of birth_____(Country/State)
10. Email address_____
11. Do you have a driver's license? ☐Yes ☐No If "Yes," provide license number, state and expiration date
    Number_____ State _____ Expiration Date _____(mm/dd/yyyy)
    If no driver's license, do you have a government issued ID? ☐Yes ☐No
    If "Yes," to government issued ID, type of ID _____ Government ID number _____

EMPLOYMENT

12. Currently employed? ☐Yes ☐No ☐Retired ☐Other_____
    If "Yes," to question 12, complete questions 13-15
13. Occupation(s) a. Title_____ b. Years at current job**_____
    **If less than one year at current job, give previous occupation information in remarks section
    c. Duties _____
14. Employer name_____
15. Work site address _____
    City_____ State_____ Zip Code_____

FINANCIAL DETAILS

16. Income (If minor, complete for Parent/Guardian)

Gross Earned Annual Income (salary, commissions, bonuses)	Gross Unearned Annual Income (dividends, pensions, interest, real estate income, etc)	Gross Annual Income (Household)	Total Net Worth (Household)
$	$	$	$

17. In the last 5 years, have you filed for bankruptcy? ☐Yes ☐No
    If "Yes," Chapter_____ Date opened_____(mm/dd/yyyy) Date Closed_____(mm/dd/yyyy)

BENEFICIARY

18. If no contingent beneficiary is named, the contingent beneficiary will be: (1) the Proposed Insured's surviving children, if any, in equal shares; or (2) if the Proposed Insured has no surviving children, the contingent beneficiary will be the Proposed Insured's estate.
    Total percentage must equal 100% for each category of beneficiary. If percentage shares are left blank, the shares will be deemed equal. If beneficiary is a Trust other than Owner, include full name and date of Trust.

Full Name	Relationship to Insured	Beneficiary Type	(%) Percentage
		☐Primary ☐Contingent	
		☐Primary ☐Contingent	
		☐Primary ☐Contingent	

PURPOSE OF INSURANCE

Complete questions 19 and 20 only if Proposed Insured and Owner are same. If Owner is different from Proposed Insured(s) and completing Owner's Questionnaire, do not complete this section.

19. Complete for Personal Insurance

☐Income Replacement ☐Mortgage/Debt Repayment ☐Estate Planning ☐Charitable/Gifting ☐Other _____

20. Complete for Business Insurance

☐Key Person ☐Buy-Sell ☐Deferred Comp ☐Other (please specify)_____

☐Loan indemnification (Security for Loan) Amount of loan $ _____ Duration _____

Interest charged on loan _____ Collateral pledged to secure loan _____

a. Type ☐Sole Proprietorship ☐Partnership ☐Corporation ☐Limited Liability Corp.

b. Name of business_____ Nature of business_____

c. How long has the business been in operation?_____ Years

d. % of business owned by Proposed Insured _____%

e. Fair market value of the business: $_____

f. Are all members of the business being similarly insured? ☐Yes ☐No

If "Yes," provide details of business coverage issued or applied for on other members. (Use remarks section if additional space is needed)

Name and Title	% of Business Owned	Amount In Force or Applied for

g. Has the business filed for bankruptcy and/or reorganization in the past 5 years? ☐Yes ☐No

If "Yes," explain_____

h. Business/Corporation finances: (Complete chart below for the past 2 years)

Year	Assets	Liabilities	Gross Sales	Net Profit
	$	$	$	$
	$	$	$	$

OTHER INSURANCE

If questions 21a, b or c are answered "Yes," please provide details in charts below. (Use remarks section if additional space is needed)

21. Including any policies and riders with the Company checked on page 1 above section A of the Application its affiliates and any other life insurance company:

a. Do you have any life insurance / annuities currently in force, including any policy that has been sold, settled or assigned to or with a settlement or viatical company or any other person or entity? ☐Yes ☐No

b. Will the coverage applied for replace, change, or affect any existing policy(ies) or contract(s)? ☐Yes ☐No

c. Do you have any other formal life insurance applications pending? ☐Yes ☐No

d. Including this application, what is the total amount of life insurance coverage pending (base policy face amount plus amounts attributable to additional benefits and riders) that you plan to accept on the Proposed Insured? _____

Chart for questions 21a and b

Name of Company	Total Amount (Face Plus Riders)	Year Issued	Policy/ Contract #	P-Personal G-Group B-Business A-Annuity	To Be Replaced Changed or Affected	1035 Exchange
				☐P ☐B ☐G ☐A	☐Yes ☐No	☐Yes ☐No
				☐P ☐B ☐G ☐A	☐Yes ☐No	☐Yes ☐No
				☐P ☐B ☐G ☐A	☐Yes ☐No	☐Yes ☐No

Chart for question 21c

Name of Company	Total Amount (Face Plus Riders)	Competitive or Additional
	$	☐Competitive ☐Additional
	$	☐Competitive ☐Additional

PERSONAL HISTORY

22. Have you ever had a driver's license suspended, revoked or restricted? ☐Yes ☐No

23. Have you in the last 5 years, been convicted of, or pled guilty or no contest to reckless or negligent driving, any moving violations or driving under the influence of alcohol or drugs? ☐Yes ☐No

24. Have you in the last 2 years been disabled for 2 or more weeks? ☐Yes ☐No

Complete if any answer to question(s) 22 through 24 is "Yes." (Use remarks section if additional space is needed)

Question #	Date (mm/dd/yyyy)	Description of Event

25. Do you engage in regular exercise? (For example, running, walking, strength training, tennis) ☐Yes ☐No
If "Yes," give details of type, frequency and length of time_____
_____

26. Have you ever had an application for life or health insurance declined, postponed, required an extra premium, offered with a reduced face amount or other modification or had a life or health policy or contract that was cancelled, recalled or denied renewal? *(If "Yes," please state companies and provide full details in remarks section)* ☐Yes ☐No

27. Have you in the last 10 years, been convicted of, or pled guilty or no contest to a felony, or are current felony charges pending? ☐Yes ☐No
(If "Yes," state offense and penalty, date of probation, duration of probation and end date in remarks section)

28. Do you expect to travel outside of the U.S. or Canada, or change your country of residence in the next 2 years? *(If "Yes," complete Foreign Travel Questionnaire)* ☐Yes ☐No

29. In the last 2 years have you:
a. Flown other than as a passenger or do you plan to do so? *(If "Yes," complete Aviation Questionnaire)* ☐Yes ☐No
b. Engaged or do you plan to engage in motor racing on land or water, underwater diving, skydiving, ballooning, hang gliding, parachuting or flying ultra-light aircraft or other hazardous sports or hobbies? *(If "Yes," complete Avocation Questionnaire)* ☐Yes ☐No

30. Are you a member of the armed forces, including the reserves? ☐Yes ☐No
(*If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces*)

ALCOHOL/DRUG/ TOBACCO USE

31. Have you ever received medical treatment or counseling for, or been advised by a physician to reduce or discontinue, the use of alcohol or prescribed or non-prescribed drugs? *(If "Yes," complete Substance Usage Questionnaire)* ☐Yes ☐No

Do not complete if Proposed Insured is age 0-17

32. Do you currently use or have you ever used tobacco or nicotine products? ☐Yes ☐No
(If "Yes," provide details in chart below)

Product Type(s)	Amount and Frequency Indicate amount and frequency of use	Indicate date last used (mm/yyyy)
☐Cigarettes	#____per ☐Day ☐Month ☐ Year	
☐Cigars ☐Cigarillos	#____per ☐Day ☐Month ☐ Year	
☐Pipe ☐Chewing Tobacco ☐Nicotine Patch or Gum	Not Applicable	
☐Other (please specify) _____		

MEDICAL CERTIFICATION

Section to be completed only when submitting medical examinations of another insurance company

If "Yes" to questions 34 or 35, complete a Medical Information Questionnaire

33. Name of Insurance Company_____ Date of Exam_____ (mm/dd/yyyy)

34. To the best of your knowledge and belief, have there been any changes to the statements in the examination? ☐Yes ☐No

35. Have you consulted a medical doctor or other practitioner since the examination indicated in question 33 above? ☐Yes ☐No

SOURCE OF FUNDS

Questions 36 and 37 not required if completing Owner's Questionnaire

36. Do you intend to finance any of the premium required to pay for this policy through a financing or loan agreement? ☐Yes ☐No
(If "Yes," submit a copy of the financing or loan agreement)

37. Indicate the source of funds used to purchase this insurance.
☐Income ☐Investments/Savings ☐ Loans ☐Gifts / Inheritance
☐Settled Contracts (give details) _____ ☐Other (please specify)_____

JUVENILE INSURANCE

COMPLETE IF PROPOSED INSURED IS UNDER AGE 15
Medical Information Questionnaire is also required

38. a. Total amount of Insurance in force on the life of: Applicant $_____
Parent(s)/Legal Guardian if other than Applicant $_____

b. Any other children in the family insured for a lesser amount? ☐ Yes ☐ No If "Yes," details_____

_____

c. Is Applicant different from the Owner? ☐ Yes ☐ No Applicant's Name _____

Applicant's SSN _____ Relationship to Proposed Insured_____

Applicant's Address_____
No. & Street Bldg./Apt./Suite City/Municipality State Zip Code

MONEY PAID WITH APPLICATION

COMPLETE IF MONEY IS PAID WITH APPLICATION

Insurability Questions for Limited Temporary Insurance Agreement

39. Is any Proposed Insured less than 15 days or over 70 years of age? ☐Yes ☐No

40. Within the past 24 months has any Proposed Insured been attended by a care provider or been seen at a medical facility for heart condition or disease, stroke or cancer? ☐Yes ☐No

41. Within the past 10 years has any Proposed Insured been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? ☐Yes ☐No

42. Within the past 12 months has any Proposed Insured: been admitted, or advised by a medical professional to be admitted, to a hospital or other licensed health care facility; had surgery performed or recommended; or been advised by a medical professional to have any diagnostic test (excluding AIDS-related test) that was not completed? ☐Yes ☐No

43. Other than planned routine check-ups, does the proposed insured have concerns or symptoms for which a medical professional has not yet been consulted? ☐Yes ☐No

44. Within the past 24 months has any Proposed Insured been declined for a life, health or Long Term Care policy? ☐Yes ☐No

COMPLETE ONLY IF "NO" TO ALL QUESTIONS IN 39-44 IN SECTION A OF THIS APPLICATION AND QUESTIONS 36 to 41 IN THE SURVIVORSHIP PRODUCT QUESTIONNAIRE, IF APPLICABLE. IF ANY OF QUESTIONS 39-44 in SECTION A OF THIS APPLICATION OR QUESTIONS 36 to 41 OF THE SURVIVORSHIP PRODUCT QUESTIONNAIRE, IF APPLICABLE, ARE ANSWERED "YES" or LEFT BLANK A PREMIUM MAY NOT BE PAID BEFORE THE POLICY IS DELIVERED AND NO TEMPORARY INSURANCE WILL BE IN EFFECT.

45. Is money paid with this Application? ☐Yes ☐No If "Yes," amount paid $_____

If "Yes," and an amount paid is indicated above, complete and sign the Temporary Insurance Agreement

REMARKS

When providing details to questions, please reference question number. If additional space is needed, attach additional sheet(s) of paper with your name and signature.

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

(Referred to below as "the Company(ies)")

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

THIS DOCUMENT MUST BE COMPLETED, SIGNED AND SUBMITTED WITH ENTIRE APPLICATION

ACKNOWLEDGEMENT OF OUR UNDERWRITING PROCESS

I (We) acknowledge that I (we) have reviewed the statement of the Underwriting Process of the Company(ies) (the ''Statement'') which describes from whom and why the Company(ies) obtains information about me (us), to whom such information may be reported and how I (we) may obtain a copy of it. The Statement contains the notice required by the Fair Credit Reporting Act.

I (We) acknowledge that in the event the Company(ies) use lab results from another insurance company authorized by me (us) it does so with the belief that I (we) have satisfied all consent and disclosure procedures for the other insurance company.

AUTHORIZATION TO OBTAIN NON-HEATH INFORMATION

I (We) authorize any employer, business associate, government unit, financial institution, consumer reporting agency, the Medical Information Bureau, my (our) insurance agency and my (our) financial professional to disclose to the Company(ies) and its authorized representatives any information they may have about my (our) occupation, avocations, insurance activities, finances, driving record, character and general reputation(s). I (We) authorize the Company(ies) to obtain investigative consumer reports, as appropriate.

PURPOSE OF AUTHORIZATIONS

I (We) understand that the information obtained will be used by the Company(ies) to determine my (our) eligibility for life insurance coverage and such other uses specified in the Statement attached to this application. In addition, information may be disclosed to the Medical Information Bureau (MIB).

COVERAGE CONDITIONS

I (We) understand that the Company(ies) may not issue coverage unless I (we) provide this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

ADDITIONAL AUTHORIZATIONS

I (We) understand that the Company(ies) may request additional authorizations in order to obtain the information the Company(ies) needs to complete its review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy, I (we) understand that I (we) am (are) not required to provide these authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected.

DURATION

Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company(ies) declines my application for coverage or, if a policy is issued, 24 months from the date of my (our) application. I (We) understand that I (we) may revoke my (our) authorizations at any time, except to the extent that the Company(ies) has (have) taken action in reliance on this authorization, and that this application and any claim made under the policy, if issued, may be rejected. My (Our) revocation must be submitted in writing to: Corporate Chief Underwriter, [1290 Avenue of the Americas, New York, New York 10104.]

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

AUTHORIZATION IF BANK DRAFT IS ELECTED

I (We) request and authorize my (our) Bank to charge monthly or quarterly my (our) checking account to pay premiums due under the policy(ies). It is understood that debits will be made automatically after the effective date determined by the Company checked on page 1 above section A of the Application and/or any other affiliated companies and if charges are overlooked or inadvertently not made, the Company checked on page 1 above section A of the Application and/or any other affiliated companies may charge my (our) account at a later date provided the policy(ies) is (are) active.

I (We) understand that the use of the Bank Draft Payment Plan does not change any policy provision.

I (We) understand this authorization is to remain in full force and in effect, unless terminated. I (We) understand this Plan may be terminated by the depositor, the Owner or the Company checked on page 1 above section A of the Application and/or any other affiliated companies. upon 30 days written notice to the other parties or if any charge due is not paid or is reversed by the Bank. I (We) understand this Plan may be terminated upon closing of my account.

I (We) understand if this Plan is terminated, premiums for regular or scheduled premium policies will be payable directly to the Company checked on the page 1 of section A of the Application.

I (We) agree that this Plan may be terminated if any debit is not honored by my (our) Bank or Depository for any reason. I (We) further agree that if any such charge is dishonored, whether with or without cause and whether intentionally or inadvertently, Company checked on page 1 above section A of the Application and/or any other affiliated companies shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance.

AGREEMENT

Each signer of this Application agrees that:

1) Except when the required money is paid with this Application and as stated in any Temporary Insurance Agreement/Receipt, no insurance shall take effect on this Application: (a) until the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; (b) before any Register Date of the policy; and (c) unless the statements and answers in all parts of this Application and any applicable supplements continue to be true and complete to the best of my (our) knowledge and belief, without material change, as of the latest of the date: (i) the policy and all amendments are delivered to the Owner(s); (ii) all delivery requirements have been completed; and (iii) the full initial premium is paid while the person(s) proposed for insurance is (are) living.

2) If temporary insurance is to be provided, the full initial premium must accompany this Application; the Proposed Insured(s) and Owner(s) understand and agree to the terms of the Temporary Insurance Agreement/Receipt and have executed and the Owner(s) has received a copy of the Temporary Insurance Agreement/Receipt.

3) The Temporary Insurance Agreement/Receipt states the conditions that must be met before any insurance takes effect if the full initial premium is paid with this Application. Temporary insurance is not provided for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.

4) No financial professional or medical examiner has authority to modify this Application and/or its supplements or questionnaires, the Temporary Insurance Agreement/Receipt (if applicable), and/or to waive any of our rights or requirements.

5) We shall not be bound by any information unless it is stated in Application Part 1, Application Part 2 or any of its supplements or questionnaires.

6) I (We) acknowledge receipt of the Living Benefits Brochure (Accelerated Death Benefit Rider Brochure), where applicable.

7) I (We) acknowledge that no representation is made that a particular rate or risk classification is being offered based on the information provided in response to the policy Application questions.

8) If applicable, the Trustee(s) represent(s) that the Trust named as Owner is allowed to purchase life insurance and securities under the trust document. I (We) further represent that beneficial interests in the Trust are at this time, and currently intend to be, only for parties who are related closely by blood or law, and have a substantial interest in the Proposed Insured(s) engendered by love and affection, or those who have a lawful and substantial economic interest in the continued life of the Proposed Insured(s).

9) I/We represent and certify to the Company checked on page 1 above section A of the Application and/or any other affiliated companies that none of the monies utilized to fund this policy derived directly or indirectly from illegal activities or sources and/or tax evasion

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under the penalties of perjury, I (we) certify that (i) the number showing on this form is my (our) correct Taxpayer Identification Number (Social Security Number, Employer Identification Number or other Taxpayer Identification Number), and (ii) I (we) am (are) not subject to backup withholding because (A) I (we) am (are) exempt from backup withholding or (B) I (we) have not been notified by the Internal Revenue Service (IRS) that I (we) am (are) subject to backup withholding as a result of a failure to report all interest or dividends or (C) the IRS has notified me (us) that I (we) am (are) no longer subject to backup withholding and (iii) I (we) am (are) a U.S. person (including a U.S. resident alien). Certification Instructions: You must cross out item (ii) above if you have been notified by the Internal Revenue Service that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return. The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

SECTION D-AUTHORIZATION/AGREEMENT SIGNATURE

STATE FRAUD DISCLOSURES

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING AN INTENTIONALLY FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

ARKANSAS AND DISTRICT OF COLUMBIA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

ACKNOWLEDGMENTS

I (We) have a right to ask for and receive copies of this Acknowledgment and Authorization Form and all other authorizations signed by me (us). I (We) agree that reproduced copies will be as valid as the original.
PLEASE INDICATE YOU HAVE REVIEWED THE APPLICATION AND QUESTIONNAIRES AS THEY HAVE BEEN COMPLETED BY CHECKING THE APPROPRIATE BOX(ES) BELOW. FAILURE TO CHECK THE APPROPRIATE BOX(ES) WILL REQUIRE YOU TO SIGN AN APPLICATION AMENDMENT.

☐ Section A –Proposed Insured Information

Section B-Product Information (Must select at least 1 product)
[☐Term Life
☐Universal Life (Athena UL)
☐Indexed Universal Life (Athena IUL) (I have received a copy of the Client Brochure for the policy)
☐Variable Universal Life (IL Optimizer II)
☐Variable Universal Life (IL Legacy II)
☐Survivorship Universal Life (ASUL III)
☐Survivorship Variable Universal Life (SIL Legacy)
☐Interest Sensitive Whole Life (ISWL)
☐Employer Sponsored Life Insurance (ESLI)
☐Corporate Owned IL (COIL)]

Section C-Additional Underwriting Requirements
[☐Owner Questionnaire
☐Foreign Residence and Travel Information Questionnaire
☐Medical Information Questionnaire
☐Financial Information Questionnaire
☐Children's Term Insurance Rider Questionnaire
☐Substance Usage Questionnaire
☐Aviation Questionnaire
☐Avocation Questionnaire
☐Term Policy/Rider Conversion or Purchase Option Questionnaire
☐Long Term Care Services Rider Questionnaire (I have received the Outline of Coverage and Personal Worksheet)]

SIGNATURES

I (We), the undersigned agree that the statements and answers in all parts of the Application and any application questionnaires checked above are true and complete to the best of my (our) knowledge and belief. Further, I (we) understand that I am (we are) agreeing to all the terms and conditions of this application, including, but not limited to, the Acknowledgment and Authorization.

X_____ X_____
Signature of Proposed Insured 1 Signature of Proposed Insured 2
(Parent, Guardian, or Applicant if Proposed Insured is a Child, Issue Ages 0−14)

X_____ _____ _____
Signature of Owner or Applicant if not Proposed Insured(s) Signed by Owner at City, State Dated on (mm/dd/yyyy)
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

FINANCIAL PROFESSIONAL TO COMPLETE THIS SECTION

Will any existing insurance be replaced, changed or affected (or has it been) assuming the insurance applied for will be issued? ☐Yes ☐No
If "Yes," is the information provided in question 21 on Part 1 of the Application for Proposed Insured 1, and question 21 of the Survivorship Product Questionnaire for Proposed Insured 2, if applicable, complete and accurate? ☐Yes ☐No
If "No," provide details_____

I certify that I have asked and recorded completely and accurately the answers to all questions on the fully completed Application Part 1, and know of nothing affecting the risk that has not been recorded herein.
☐ I have witnessed the signature required on the fully completed Part 1.
☐ I have not witnessed the signature required on the fully completed Part 1. (Explain below.)

_____

For VUL Policies Only:
Based on the information furnished by the Proposed Insured(s) and Owner, if other than the Proposed Insured(s), in this and any other part of the application(s), I certify that I have reasonable grounds for believing the purchase of the policy applied for is suitable for the Applicant or the Owner. I further certify the current prospectuses were delivered and that no written sales materials other than those furnished by the Company were used.

X_____ _____
Signature of Licensed Financial Professional/Insurance Broker Dated on (mm/dd/yyyy)

Print Licensed Financial Professional's Name_____ License Number_____

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION B—TERM LIFE INSURANCE

Name of Proposed Insured_____ Date of Birth_____

PLAN INFORMATION

1. Product Name (Check One)

[☐Level Term 10 ☐Annual Renewal Term
☐Level Term 15 ☐OneYear Term
☐Level Term 20]

2. Amount of Insurance $_____

3. Backdate to save age ☐Yes ☐No
Max 6 months prior to application date (3 months in OH)
(Premiums for insurance coverage begin on the backdated Register Date)

PREMIUM INFORMATION

4. Premium Mode

a. Direct Billing (By Mail) ☐ Annually* ☐ Semi-Annually ☐ Quarterly

**Annually is the only payment mode available for the OneYear Term product*

b. Bank Draft** ☐ Monthly Draft Date is the same as the Register Date
(Voided Check Required)
***If bank account holder is not the Owner or Proposed Insured, please complete Systematic Payment Enrollment Form*

☐ In lieu of voided check, use first premium check to set up Systematic Payment Plan

c. Salary Allotment ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

Unit name _____ Unit number _____ Register Date _____(mm/dd/yyyy)

If Allotter is not Proposed Insured, provide Name _____ SSN/EIN/ITIN_____

OPTIONAL BENEFITS/RIDERS

5.

[☐ Disability Premium Waiver Rider

☐ Children's Term Insurance Rider (*complete Children's Term Insurance Rider Questionnaire)*
Amount $_____]

☐ Other (as allowed or available with product)_____

MONY Life Insurance Company of America

SECTION B – FLEXIBLE PREMIUM VARIABLE UNIVERSAL LIFE INSURANCE

Name of Proposed Insured _____ Date of Birth _____

PLAN INFORMATION

1. Product Name **INCENTIVE LIFE LEGACY II (IL Legacy II)**
2. Amount of Insurance $_____
3. Is this a Term Conversion, Rider Conversion or Purchase Option? ☐ Yes ☐ No
   (If "Yes," complete Term Policy/Rider Conversion or Purchase Option Questionnaire.)
4. Death Benefit Option ☐ Option A (Level) ☐ Option B (Face Amount and Policy Account Value)
5. Backdate to save age ☐ Yes ☐ No
   Max 6 months prior to application date (3 months in OH)
   (Charges and Premiums for insurance coverage begin on the backdated Register Date.)
6. Definition of Life Insurance Test ☐ Guideline Premium Test ☐ Cash Value Accumulation Test

PREMIUM INFORMATION

7. a. Planned Periodic Premium Amount $_____ b. Initial Premium $_____
8. Premium Mode
   a. Direct Billing (By Mail) ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly
   b. Bank Draft* ☐ Quarterly ☐ Monthly Start Date _____ (dd/mm/yyyy) Draft on _____ day of the month
   (Voided Check Required)
   If bank account holder is not the Owner or Proposed Insured, please complete Systematic Payment Enrollment Form.
   ☐ **In lieu of voided check, use first premium check to set up Systematic Payment Plan**
   c. Salary Allotment ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly
   Unit name _____ Unit number _____ Register Date _____ (mm/dd/yyyy)
   If Allotter is not Proposed Insured, provide Name _____ SSN/EIN/TIN _____
   d. Single Payment Amount $_____ (No further Premium billing will be sent)

OPTIONAL BENEFITS/RIDERS

9.

☐ Long-Term Care Services Rider *(complete Long-Term Care Services Rider Questionnaire)*†
(MA only: known as Accelerated Death Benefit for Chronic Illness Rider - complete Accelerated Death Benefit for Chronic Illness Rider Questionnaire)

☐ Disability Rider – Waiver of Monthly Deductions

☐ Extended No Lapse Guarantee (ENLG) Rider

☐ Charitable Legacy Rider *(available on face amounts of $1 million and over; complete Charitable Beneficiary Information below)*

Charitable Beneficiary Information *(If more than one Charitable Beneficiary is named, the total percentage must equal 100%. If percentage shares are left blank, the shares will be deemed equal.)*

Name of Qualified Charitable Organization††	Address	501(c) Tax ID No.††† (##-#######)	% Share
1.			
2.			

☐ Children's Term Insurance Rider *(complete Children's Term Insurance Rider Questionnaire)*
Amount $_____

☐ Option to Purchase Additional Insurance Rider
Amount $_____

☐ Other (as allowed or available with product) _____

† **Not available in Florida, Minnesota, and Washington.**
†† **A qualified charitable organization is one that is exempt from federal taxation under 501(c) of the Internal Revenue Code and is Listed in Section 170(c) of the Internal Revenue Code as an authorized recipient of charitable contributions. We require that printed and dated evidence of the qualification of the charitable organization be provided with the application.**
††† **Contact the charitable organization directly to get its 501(c) Tax ID No.**

SECTION B – FLEXIBLE PREMIUM VARIABLE UNIVERSAL LIFE INSURANCE

10. INITIAL ALLOCATION TO THE INVESTMENT OPTIONS[1]

Please see the Prospectus for a description of the investment objective(s) for each Investment Option.

IF THE EXTENDED NO LAPSE GUARANTEE (ENLG) RIDER IS ELECTED, SEE FUND RESTRICTIONS ON THE NEXT PAGE.**	(Whole Percentages Only) For Premiums	For Deductions
Market Stabilizer Option[2,3]	_____%	_____%
Guaranteed Interest Account**	_____%	_____%
All Asset Allocation	_____%	_____%
American Century VP Mid Cap Value	_____%	_____%
AXA Balanced Strategy**	_____%	_____%
AXA Conservative Growth Strategy**	_____%	_____%
AXA Conservative Strategy**	_____%	_____%
AXA Growth Strategy**	_____%	_____%
AXA Moderate Growth Strategy**	_____%	_____%
AXA Tactical Manager 400	_____%	_____%
AXA Tactical Manager 500	_____%	_____%
AXA Tactical Manager 2000	_____%	_____%
AXA Tactical Manager International	_____%	_____%
EQ/AllianceBernstein Small Cap Growth	_____%	_____%
EQ/BlackRock Basic Value Equity	_____%	_____%
EQ/Boston Advisors Equity Income	_____%	_____%
EQ/Calvert Socially Responsible	_____%	_____%
EQ/Capital Guardian Research	_____%	_____%
EQ/Common Stock Index	_____%	_____%
EQ/Core Bond Index	_____%	_____%
EQ/Equity 500 Index	_____%	_____%
EQ/Equity Growth PLUS	_____%	_____%
EQ/GAMCO Mergers and Acquisitions	_____%	_____%
EQ/GAMCO Small Company Value	_____%	_____%
EQ/Global Bond PLUS	_____%	_____%
EQ/Global Multi-Sector Equity	_____%	_____%
EQ/Intermediate Government Bond Index	_____%	_____%
EQ/International Core PLUS	_____%	_____%
EQ/International Equity Index	_____%	_____%
EQ/International Value PLUS	_____%	_____%
EQ/JPMorgan Value Opportunities	_____%	_____%
EQ/Large Cap Core PLUS	_____%	_____%
EQ/Large Cap Growth Index	_____%	_____%
EQ/Large Cap Growth PLUS	_____%	_____%
EQ/Large Cap Value Index	_____%	_____%
EQ/Large Cap Value PLUS	_____%	_____%
EQ/Lord Abbett Large Cap Core	_____%	_____%
EQ/MFS International Growth	_____%	_____%
EQ/Mid Cap Index	_____%	_____%
EQ/Mid Cap Value PLUS	_____%	_____%
EQ/Money Market	_____%	_____%
EQ/Montag & Caldwell Growth	_____%	_____%
EQ/Morgan Stanley Mid Cap Growth	_____%	_____%
EQ/PIMCO Ultra Short Bond	_____%	_____%

	(Whole Percentages Only) For Premiums	For Deductions
EQ/Quality Bond PLUS	_____%	_____%
EQ/Small Company Index	_____%	_____%
EQ/T. Rowe Price Growth Stock	_____%	_____%
EQ/UBS Growth and Income	_____%	_____%
EQ/Van Kampen Comstock	_____%	_____%
EQ/Wells Fargo Omega Growth	_____%	_____%
Fidelity VIP Contrafund	_____%	_____%
Fidelity VIP Growth & Income	_____%	_____%
Fidelity VIP Mid Cap	_____%	_____%
Franklin Rising Dividends Securities	_____%	_____%
Franklin Small Cap Value Securities	_____%	_____%
Franklin Strategic Income Securities	_____%	_____%
Goldman Sachs VIT Mid Cap Value	_____%	_____%
Invesco V.I. Global Real Estate	_____%	_____%
Invesco V.I. International Growth	_____%	_____%
Invesco V.I. Mid Cap Core Equity	_____%	_____%
Invesco V.I. Small Cap Equity	_____%	_____%
Ivy Funds VIP Energy	_____%	_____%
Ivy Funds VIP Mid Cap Growth	_____%	_____%
Ivy Funds VIP Small Cap Growth	_____%	_____%
Lazard Retirement Emerging Markets Equity	_____%	_____%
MFS International Value	_____%	_____%
MFS Investors Growth Stock Series	_____%	_____%
MFS Investors Trust Series	_____%	_____%
Multimanager Aggressive Equity	_____%	_____%
Multimanager Core Bond	_____%	_____%
Multimanager International Equity	_____%	_____%
Multimanager Large Cap Core Equity	_____%	_____%
Multimanager Large Cap Value	_____%	_____%
Multimanager Mid Cap Growth	_____%	_____%
Multimanager Mid Cap Value	_____%	_____%
Multimanager Multi-Sector Bond	_____%	_____%
Multimanager Small Cap Growth	_____%	_____%
Multimanager Small Cap Value	_____%	_____%
Multimanager Technology	_____%	_____%
Mutual Shares Securities	_____%	_____%
PIMCO VIT CommodityRealReturn Strategy	_____%	_____%
PIMCO VIT Real Return Strategy	_____%	_____%
PIMCO VIT Total Return	_____%	_____%
T. Rowe Price Equity Income II	_____%	_____%
Templeton Developing Markets Securities	_____%	_____%
Templeton Global Bond Securities	_____%	_____%
Templeton Growth Securities	_____%	_____%
Van Eck VIP Global Hard Assets	_____%	_____%
TOTAL	**100%**	**100%**

[1,2,3,**] please see next page for important information

SECTION B – FLEXIBLE PREMIUM VARIABLE UNIVERSAL LIFE INSURANCE

INVESTMENT OPTIONS

[1] The "Investment Start Date" is the business day your investment first begins to earn a return for you, as described below, and is generally the later of: (1) the business day we receive the minimum initial premium at our Administrative Office; and (2) the Register Date of your policy.

Your Policy Account (except any amounts you allocated to the Guaranteed Interest Account) will be allocated to the EQ/Money Market investment option as of the later of: (1) the Investment Start Date; and (2) the Issue Date, for 20 calendar days (Money Market Lock-in Period), and will be allocated according to the above percentages on the 1st business day following the Money Market Lock-in Period. However, if we have not received all necessary requirements for your policy as of the Issue Date, the Money Market Lock-in Period will begin on the date we receive, at our Administrative Office, all necessary requirements to put the policy in force.

Any payments we receive prior to your Investment Start Date will be held in a non-interest bearing account until your Investment Start Date.

[2] If you elect the Market Stabilizer Option, the portion of your Policy Account, per the above premium percentage for such option, will be allocated as stated above.

Such portion of your Policy Account will be allocated to the EQ/Money Market Investment Option for 20 business days. If the policy is issued as result of a replacement, such portion of your Policy Account will remain in the EQ/Money Market Investment Option for 30 calendar days (60 calendar days in NY). However, if we have not received all necessary requirements for your policy as of the Issue Date, the period of time during which amounts will remain in the EQ/Money Market Investment Option will begin on the date we receive, at our Adminstrative Office, all necessary requirements to put the policy in force. Thereafter, such portion of your Policy Account will be allocated to the Market Stabilizer Option Holding Account until the next avaliable Segment Start Date, at which time such amount will be transfered to the Market Stabilizer Option, provided that the conditions specified in the rider and the Propectus are met.

[3] Any percentages specified for deductions for the Market Stabilizer Option will apply only to the Market Stabilizer Option Holding Account prior to a Segment Start Date.

** If the Enhanced No Lapse Guarantee Rider is elected, Investment Options are limited only to the funds **bolded** on the previous page. Specify Premium allocations only (do not specify Deduction allocations).

ALLOCATIONS IF THE MARKET STABILIZER OPTION IS ELECTED

11. ☐ Market Stabilizer Option (Variable Indexed Option Rider)

Specified Growth Cap Rate _____% *(indicate a Growth Cap Rate between 6% and 10% in whole percentages only)*

If the Growth Cap Rate MONY Life Insurance Company of America sets on a given Segment Start Date is less than the rate you specify, any Policy Account Value you have in the Market Stabilizer Option Holding Account will not be transferred into that Segment. If you do not indicate a Specified Growth Cap Rate, the Specified Growth Cap Rate will be set to 6%, the guaranteed minimum Growth Cap Rate, and funds will transfer into a new Segment on all available Segment Start Dates, provided the conditions specified in the rider and Prospectus are met.

SECTION B – FLEXIBLE PREMIUM VARIABLE UNIVERSAL LIFE INSURANCE

TRANSFERS FROM THE VARIABLE INVESTMENT OPTIONS TO SUPPLEMENT THE UNLOANED GUARANTEED INTEREST ACCOUNT (GIA)

If you elect the Market Stabilizer Option, monthly deductions will be allocated 100% to the unloaned GIA on a Segment Start Date. If the unloaned GIA is not sufficient to cover such monthly deductions for the longest Segment Term, funds will be transferred pro-rata from amounts in the Variable Investment Options, including the Market Stabilizer Option Holding Account, to the unloaned GIA to supplement any remaining monthly deductions. You may also specify deduction percentages below for transferring amounts from the Variable Investment Options to supplement the unloaned GIA.

12. ☐ Check here if you wish transfers to be made pro-rata from amounts in all available Variable Investment Options, including the Market Stabilizer Option Holding Account, to supplement the unloaned GIA. If this box is not checked, please specify below the Variable Investment Options from which amounts should be transferred to supplement the unloaned GIA.

Variable Investment Options to Transfer from (complete only if 12. is not checked):	Percentage (whole percentages only):
_____	_____%
_____	_____%
_____	_____%
_____	_____%
_____	_____%
_____	_____%
_____	_____%
	TOTAL 100%

SEGMENT MATURITY ALLOCATION

Each Segment of the Market Stabilizer Option has a Segment Maturity Date, which is approximately one year following a Segment Start Date. You may specify the investment option allocation percentages for the rollover of the Segment Maturity Value.

13. ☐ Check here if you wish to rollover your Market Stabilizer Option Segment Maturity Value to a new Segment. If this box is not checked, indicate allocations for rollover of the Segment Maturity Value below. Please note that by electing less than 100% rollover, the total portion of your Policy Account Value allocated to the Market Stabilizer Option will continually decrease as future rollovers occur, if no other changes were made. For example, a Segment Maturity Allocation of 50% to the Market Stabilizer Option will rollover 50% of the original Market Stabilizer Option allocation in year 2 but only 25% (50% x 50%) of the original Market Stabilizer Option allocation in year 3.

Investment Options for Rollover (complete only if 13. is not checked):	Percentage (whole percentages only):
_____	_____%
_____	_____%
_____	_____%
_____	_____%
_____	_____%
_____	_____%
_____	_____%
	TOTAL 100%

SUITABILITY

14.

a. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received:
   (1) the most current prospectus, and supplement(s) if applicable, for the policy(ies) applied for? ☐ Yes ☐ No
   (2) the most current prospectus, and supplement(s) if applicable, for the designated investment company(ies)? ☐ Yes ☐ No

b. Do you understand that (i) policy values reflect certain deductions and charges, and may increase or decrease depending on credited interest for the Guaranteed Interest Account and/or the investment experience of Separate Account Funds and (ii) the cash value may be subject to a surrender charge, if any, upon policy surrender, lapse or face amount reduction? ☐ Yes ☐ No

c. With this in mind, is (are) the policy(ies) in accord with your insurance and long-term investment objectives and anticipated financial needs? ☐ Yes ☐ No

d. Disclosures and Consent for Delivery of Initial Prospectus on CD-Rom for MONY Life Insurance Company of America Variable Life products.

☐ By checking the box you acknowledge that you received the initial prospectus on computer readable compact disk "CD" if available for the product chosen, and that you are able to access the CD information. In order to retain the prospectus indefinitely, you must print it. You understand that you may request a prospectus in paper format at any time by calling Customer Service at 1-877-222-2144, and that all subsequent prospectus updates and supplements will be provided to you in paper format, unless you enroll in our electronic delivery service.

SECTION B – FLEXIBLE PREMIUM VARIABLE UNIVERSAL LIFE INSURANCE

AUTOMATIC TRANSFER SERVICE

15. Note: Not available if you elect the Asset Rebalancing Service or the Extended No Lapse Guarantee (ENLG) Rider.

The Automatic Transfer service enables you to make automatic monthly or quarterly transfers from the EQ/Money Market Investment Option to other variable investment options that you select. A minimum of $5,000 must be allocated to the EQ/Money Market Investment Option. Up to 8 investment options can receive the monthly automatic transfer. Each transfer must be at least $50. The automatic transfer is effective on the second monthly anniversary and will continue until the amount allocated to the EQ/Money Market Investment Option is depleted.

Investment Options to Receive Transfer:	Dollar Amount:
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

I (We), have read the detailed description of the Automatic Transfer Service in the prospectus. My (Our) instructions will remain in effect until (a) insufficient funds are available to process transfers, (b) I (we) provide new written instructions or (c) the Automatic Transfer Service otherwise terminates as described in the prospectus. I (We) understand that use of the Automatic Transfer Service does not guarantee a profit and will not protect against loss in a declining market.

ASSET REBALANCING SERVICE

16. Note: Not available if you elect the Automatic Transfer Service or the Extended No Lapse Guarantee (ENLG) Rider.

Neither the Guaranteed Interest Account nor the Market Stabilizer Option are available for Asset Rebalancing. Your allocation among the investment options will be periodically re-adjusted according to the percentage you indicated in Question 10 and the frequency you choose below. Asset allocation percentages of 2% or more (in whole percentages) may be specified for all variable investment options up to a maximum of 50 options. Asset Rebalancing is effective on the first monthly anniversary ofter the Money Market Lock-in Period ends.

☐ Annually ☐ Semi-annually ☐ Quarterly

I (We), have read the detailed description of the Asset Rebalancing Service in the prospectus. My (Our) instructions will remain in effect until (a) I (we) provide new written instructions or (b) Asset Rebalancing otherwise terminates as described in the prospectus. I (We) understand that the use of the Asset Rebalancing Service does not guarantee a profit and will not protect against loss in a declining market.

I (WE) UNDERSTAND THAT THE POLICY VALUES AND THE DEATH BENEFIT MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE INVESTMENT EXPERIENCE OF THE VARIABLE SUBACCOUNTS (SUBJECT TO ANY SPECIFIED MINIMUM GUARANTEES).

SECTION C—ACCELERATED DEATH BENEFIT FOR LONG-TERM CARE SERVICES RIDER (IN MA IT IS CALLED ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER) QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR INSURANCE

Disclosure: The receipt of Long-Term Care benefits may be taxable. You, the Owner, should consult your tax advisor as to the taxation of any Long-Term Care benefits received.

Name of Proposed Insured_____ Date of Birth_____(mm/dd/yyyy) Policy # (if known)_____
(mm/dd/yyyy)

LONG-TERM CARE SPECIFIED AMOUNT AND MAXIMUM MONTHLY BENEFIT

1. The Long-Term Care Specified Amount applied for equals the initial face amount of the base policy.
The Maximum Monthly Benefit equals the initial Long-Term Care Specified Amount, multiplied by the benefit percentage chosen by the owner. Select one benefit percentage:

[☐ 1% ☐ 2% ☐ 3%]

If a benefit percentage is not chosen, the default benefit percentage is: [(a) 2% if the initial face amount of the base policy is less than or equal to $2,500,000; and (b) 1% if the initial face amount is greater than $2,500,000, but not to exceed $5,000,000.]

PROTECTION AGAINST UNINTENDED TERMINATION

2. I, the Owner, understand that I have the right to designate at least one person other than myself to receive written notice of lapse or termination of the policy to which this rider is attached. I understand that such notice will not be sent until 30 days after the rider charge is due and unpaid.

☐ I elect to designate a person to receive such notice (complete information below)
☐ I DO NOT elect to designate a person to receive such notice.

Owner's name _____

Home Address No and Street_____ Bldg/Apt/Ste_____

City_____ State_____ Zip Code_____

GENERAL INFORAMTION (Proposed Insured)

3.

a. Are you covered by Medicaid? ☐ Yes ☐ No
b. Do you currently have, or have you had during the last 12 months, another accident and health or long-term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? ☐ Yes ☐ No
c. Do you intend to replace any of your long-term care, medical, or health coverage with the coverage applied for? ☐ Yes ☐ No
d. Do you have any other life insurance policies currently in force that provide similar long-term care coverage? ☐ Yes ☐ No
e. Have you ever been denied coverage for a long-term care insurance rider or policy? If yes, provide details: ☐ Yes ☐ No

_____
_____
_____

DETAILS FOR "YES" ANSWERS TO GENERAL INFORMATIONS (Questions

Company	Policy/Certificate No.	Type and Amount	Currently in force?		Being Replaced?	
			Yes	No*	Yes	No
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

*Provide date of lapse for any insurance not currently in force:

FINANCIAL PROFESSIONAL TO COMPLETE THIS SECTION

List any other health or long-term care insurance policies that are currently in force:

Company	Policy No.	Type and Amount

List any other health or long-term care insurance policies in the last 5 years that are no longer in force:

Company	Policy No.	Type and Amount

MEDICAL INFORMATION (Proposed Insured)

4.

a. Do you currently use any medical devices, such as: a wheelchair, walker, hospital bed, dialysis machine, oxygen, or stair lift? ☐ Yes ☐ No

b. Do you currently need or receive help in doing any of the following: bathing, eating, dressing, toileting, transferring, from bed to chair? ☐ Yes ☐ No

c. Do you currently have, or have you ever been diagnosed or treated by a member of the medical profession for symptoms of:
   i. Alzheimer's Disease, dementia, or organic brain syndrome? ☐ Yes ☐ No
   ii Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease), or Parkinson's Disease? ☐ Yes ☐ No

d. Within the last 5 years, have you had symptoms, received medical advice, diagnosis or treatment from, or consulted with, a member of the medical profession for:
   i. transient ischemic attack, stroke, depression, seizures, tremors, injury due to falls or imbalance, or memory loss? ☐ Yes ☐ No
   ii. bladder disorders, prostate disorders, disorders of the reproductive organs, liver disorders, or incontinence problems? ☐ Yes ☐ No
   iii. osteoporosis, arthritis, or fractures? ☐ Yes ☐ No

e. Do you currently reside in, have been advised to enter, or are planning to enter a nursing home, assisted care living facility, custodial facility, or have you ever received or are you currently receiving home health care services or attending an adult day care center? ☐ Yes ☐ No

Details for "Yes" answers to 4a-e

Question Letter	Illness, Treatment (include specific diagnosis and medication)	Onset Date	Recovery Date	If disabled, how long?	Doctor, Clinic, or Hospital Complete Address, and Phone Number

AGREEMENT & ACKONWLEDGEMENT

I agree as follows: I, the Owner, am applying for an acceleration of life insurance death benefits under the Accelerated Death Benefit for Long-Term Care Services Rider that will become part of the life insurance policy that I applied for. The statements and answers in this application are true and complete to the best of my knowledge and belief. If any statements and answers in this application are not complete, true, or correctly recorded, I understand that the Company checked on page 1 above section A of the application and/or any other affiliated companies has the right to deny benefits or rescind the rider applied for. I, the Owner, understand that this application will form part of the basis of coverage under the policy I applied for and that coverage for this rider will take effect on the Register Date of the policy. I understand that this rider covers only the insured person named in the policy.

Acknowledgement: I have received the rider Outline of Coverage and the Shopper's Guide to Long-Term Care Insurance (if required by law in the state in which the rider is delivered.)

Under the Federal income tax law, I, the Owner, have the right to elect not to have withholding taxes apply. I acknowledge that I do not want any Federal income tax withheld relating to any taxable distributions deducted from my policy account value to pay the monthly cost for this rider. This acknowledgement will be valid on the date signed and is effective until revoked.

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SECTION C--OWNER QUESTIONNAIRE --FORMING PART OF THE APPLICATION FOR LIFE INSURANCE *Complete if other than Proposed Insured*

Name of Proposed Insured_____ ___ Date of Birth_____(mm/dd/yyyy)

COMPLETE FOR ALL OWNER TYPES

For Joint Owners provide name, residential address, Social Security #, date of birth, driver's license #, state of issue and expiration date, occupation and employer's name in Remarks Section on the Application.

1. Owner Type ☐Individually Owned ☐Partnership ☐Corporation ☐Trust ☐LLC ☐Sole Proprietorship
2. Owner's name _____
3. Relationship to Proposed Insured _____
4. ☐SSN ☐EIN ☐ITIN _____ 5. Email address_____
6. Address _____

   City_____ State_____ Zip Code_____

   If P.O. Box, put residential address in Remarks Section.

Complete if Owner Type is Partnership, Corporation, Trust, LLC, Sole Proprietorship

7. Person(s) authorized to act on behalf of Owner

   Name _____ Title_____

   Name_____ Title_____

COMPLETE IF INDIVIDUALLY OWNED

8. Do you have a driver's license? ☐Yes ☐No If "Yes," provide license #, state and expiration date

   Number_____ State _____ Expiration Date _____ (mm/dd/yyyy)

   If no driver's license, do you have a government issued ID? ☐Yes ☐No

   If "Yes," to government issued ID, type of ID _____ Government ID #_____

9. Date of birth_____ (mm/dd/yyyy) 10. Currently employed? ☐Yes ☐No ☐Retired *(If "Yes," complete question 11)*
11. Occupation_____ Employer name_____
12. Income

Gross Earned Annual Income (salary, commissions, bonuses)	Gross Unearned Annual Income (dividends, pensions, interest, real estate income, etc)	Gross Annual Income (Household)	Total Net Worth (Household)
$	$	$	$

13. Are you a member of the armed forces, including the reserves? ☐Yes ☐No

    (If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces)

14. Are you a U.S. citizen? ☐ Yes ☐ No (If "No," please complete "a" and "b" or "c," where applicable)

    a. Country of Citizenship _____ Date of Entry into the U.S. _____ (mm/dd/yyyy)

    b. Residents with legal permanent status (Resident) in U.S. only

    Green Card/Visa Type _____ Expiration Date _____ (mm/dd/yyyy)

    c. Residents residing in the U.S. temporarily (Non-Resident) with valid Visa only

    Visa #_____ Visa Type_____ Expiration Date_____(mm/dd/yyyy)

    Form I-94 Expiration Date_____ (mm/ddd/yyyy) Passport # _____

Complete Question 15 for all non-resident (foreign) Owners. If the Owner is not a U.S. Person (U.S. Citizen or U.S. Corporation, Partnership or Trust established or organized under the laws of a state of the United States), then he, she or it may have to provide additional documentation, including IRS form W-8 BEN. Any foreign Owner (Individual, Trust, Corporation, Partnership, Other Entity) must have a US bank account).

15. U.S. bank name _____ Account #_____

OTHER INSURANCE

16. Including any policies and riders with AXA Equitable, its affiliates and any other life insurance company:

    a. Do you have any life insurance / annuities currently in force, including any policy that has been sold, settled or assigned to or with a settlement or viatical company or any other person or entity? ☐Yes ☐No

    b. Will the coverage applied for replace, change, or affect any existing policy(ies) or contract(s)? ☐Yes ☐No

    Complete as appropriate if any of questions 16a and b is "Yes"

Name of Company	Total Amount (Face Plus Riders)	Year Issued	Policy/ Contract #	P-Personal G-Group B-Business A-Annuity	To Be Replaced Changed or Affected	1035 Exchange
				☐ P ☐ B ☐ G ☐ A	☐Yes ☐ No	☐Yes ☐ No
				☐ P ☐ B ☐ G ☐ A	☐Yes ☐ No	☐Yes ☐ No

COMPLETE IF TRUST OWNED

17. Situs of Trust: The Trust is subject to the laws of the state of _____ 15. Date of Trust _____(mm/dd/yyyy)

18. Name(s) of Grantor(s)_____

19. Name(s) and title(s) of current Trustee(s)_____

20. a. How long has the Trustee known the Proposed Insured?_____

b. What is the nature of the relationship between the Proposed Insured and the Trustee?_____

c. Is the Trust? ☐Revocable ☐Irrevocable (Check appropriate box)

d. Can interests in the Trust be sold without changing the terms of the Trust? ☐ Yes ☐No

21. Did the Proposed Insured and/or the Owner retain an attorney to prepare the Trust documents? ☐Yes ☐ No

If "Yes," provide name and address of attorney. If "No," provide the name and address of the person or entity that did prepare the Trust documents.

Please provide the relationship of the preparer of the Trust to the Proposed Insured

Name_____ Relationship to the Proposed Insured _____

Address_____

22. Name(s) of current Beneficiary(ies) of the Trust_____

23. What is the nature of the relationship between the Grantor(s) and Beneficiary(ies)?_____

24. Is there a Trust Protector? ☐Yes ☐ No (If "Yes," answer 25a and b)
A Trust Protector is a third party appointed by the Grantor to provide direction and guidance to the Trustee

25. a. How long has the Trustee known the Trust Protector?_____

b. What is the nature of the relationship between the Proposed Insured and the Trust Protector?_____

PURPOSE OF INSURANCE

26. Complete For Personal Insurance

☐Income Replacement ☐Mortgage/Debt Repayment ☐Estate Planning ☐Charitable/Gifting ☐Other _____

27.Complete for Business Insurance

☐Key Person ☐Buy-Sell ☐Deferred Comp ☐Other (please explain) _____

☐Loan indemnification/Amount of loan $ _____ Duration _____

Interest charged on loan _____ Collateral pledged to secure loan _____

a. Type: ☐Sole Proprietorship ☐Partnership ☐Corporation ☐Limited Liability Corporation

b. Name of Business_____ Nature of Business_____

c. How long has the business been in operation?_____ Years d. Fair market value of the business $_____

e. % of business owned by Proposed Owner, if other than the Proposed Insured_____%

f. Are all members of the business being similarly insured? ☐Yes ☐No

If "Yes," provide details of business coverage issued or applied for on other members (use separate sheet if necessary)

Name and Title	% of Business Owned	Amount In Force or Applied for

g. Has the business filed for bankruptcy and/or reorganization in the past 5 years? ☐Yes ☐No

If "Yes," explain_____

h. Business/Corporation finances: (Complete chart below for the past 2 years)

Year	Assets	Liabilities	Gross Sales	Net Profit
	$	$	$	$
	$	$	$	$

For employer owned life insurance there are notice and consent requirements, established in the Tax Code, that must be met before issuance of the contract, as well as tax limitations on those who can be insured. When purchasing insurance on employees or directors, you should consult your tax advisor to avoid adverse tax consequences.

SOURCE OF FUNDS

28. Do you intend to finance any of the premium required to pay for this policy through a financing or loan agreement? ☐Yes ☐No

If "Yes," with whom are you financing_____

29. Indicate the source of funds used to purchase this insurance.

☐Income ☐Investments/Savings ☐ Loans ☐Gifts / Inheritance

☐Settled Contracts-give details_____ ☐Other (specify)_____

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SECTION C--FOREIGN RESIDENCE AND TRAVEL QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Name of Proposed Insured_____ Date of Birth_____ (mm/dd/yyyy) Policy # (if known)_____

FOREIGN NATIONALS

1. *If the Proposed Insured is a foreign national, you must submit a copy of a government issued photo ID evidencing nationality or residence (e.g., Passport, Alien Registration (Green Card)).*
   a. Country of Citizenship_____ Date of Entry into the U.S._____ (mm/dd/yyyy)
   b. Residents with legal permanent status (Resident) in U.S. only
      Green Card/Visa Type_____ Expiration Date_____(mm/dd/yyyy)
   c. Residents residing in the U.S. temporarily (Non-Resident) with valid visa only
      Visa #_____ Visa Type_____ Expiration Date_____ (mm/dd/yyyy)
      Passport #_____ Date of Entry into U.S. _____(mm/dd/yyyy)
      I-94 Expiration Date _____ (mm/dd/yyyy)

Complete question below for all non-resident (foreign) owners. (Individuals, businesses, corporations, trusts and partnerships that are foreign must have a U.S. bank account.)

U.S. Bank Name_____ Account Number_____

FOREIGN TRAVEL/RESIDENCE

2. Provide details for every planned stay outside the U.S. or Canada in the next year (other than a two week or less vacation).

Country	City/Location	Residence/Travel Dates Departure from U.S. mm/dd/yyyy	Return to U.S. mm/dd/yyyy	Purpose of Trip

ADDITIONAL DETAILS

Please add any additional information regarding future travel/residency that you believe was not adequately covered above

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C--MEDICAL INFORMATION QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

This form is to be completed by the Proposed Insured regarding his/her health for underwriting purposes. The completion is optional if a full Paramedical or Medical Exam is required.
Best practice is to complete this form and answer all medical questions to enable the underwriter to promptly begin the underwriting process. Incomplete information may delay your application.

PROPOSED INSURED

Policy # (if known)_____

1. Name First_____Middle_____ Last_____
2. Date of Birth _____(mm/dd/yyyy)
3. Height_____ ft. _____ in. Weight _____ (lbs.)
4. Has the Proposed Insured's weight changed by more than 10 pounds in the last 6 months? ☐Yes ☐ No
   If "Yes," Pounds Lost_____ Pounds Gained_____ Reason_____

PERSONAL PHYSICIAN

5. Does the Proposed Insured have a personal physician? ☐Yes ☐No
6. If "Yes," Physician Name or Name of Practice or Clinic_____
7. Street Address_____ City_____ State_____ Zip_____
8. Phone #_____
9. Date and reason last consulted if within the last 5 years
   a. Date (mm/dd/yyyy)_____
   b. Reason_____
10. What treatment was given or recommended? _____ ☐None

FAMILY HISTORY

11.

Relationship	Age if Living	Age at Death	Cause of Death if Deceased
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			

SECTION C-MEDICAL INFORMATION FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

MEDICAL HISTORY

If you check "Yes," to any of the conditions on questions 12-18, please give details on chart provided on page 3.
On questions12 and 13 "check all that apply" and provide details.

12. Has the Proposed Insured ever had or been treated for any of the following? ☐ Yes ☐ No

a. ☐ High Blood Pressure	h. ☐ Asthma/Bronchitis	o. ☐ Parkinson's Disease	V. ☐ Lupus
b. ☐ Chest Pain	i. ☐ Emphysema	p. ☐ Alzheimer's Disease	w. ☐ Anemia
c. ☐ Heart Attack	j. ☐ Sleep Apnea	q. ☐ Memory Loss	x . ☐ Paralysis
d. ☐ Heart Murmur	k. ☐ Eating Disorder	r. ☐ Colitis/Ulcer/Hernia	y. ☐ Seizures
e. ☐ Diabetes	l. ☐ Stroke/TIA	s. ☐ Cirrhosis	z. ☐ Tuberculosis
f. ☐ High Cholesterol	m. ☐ Depression/Anxiety	t. ☐ Hepatitis	
g. ☐ Cancer/Tumor/Polyp/Cyst	n. ☐ Multiple Sclerosis	u. ☐ Arthritis/Neuritis/Gout	

13. Other than as indicated above, has the Proposed Insured ever had any disease or disorder of any of the following? ☐ Yes ☐No

List the specific organ(s), system(s) and/or impairment(s) in the table if question contains multiple items.

a. ☐Heart	g. ☐Reproductive Organs/Breasts	m. ☐Ears/Nose/Throat
b. ☐Arteries/Veins	h. ☐Brain/Nervous System	n. ☐Lungs/Respiratory System
c. ☐Skin	i. ☐Liver/Pancreas/Gallbladder	o. ☐Muscle/Bones/Joints
d. ☐Blood	j. ☐Emotional/Psychological Disorder	p. ☐Lymph Nodes
e. ☐Eyes	k. ☐Immune System	q. ☐Thyroid/Other Glands
f. ☐Prostate	l. ☐Gastrointestinal/Digestive System	r. ☐Kidney/Bladder

14. Is the Proposed Insured now under medical observation or treatment for any reason not stated above? ☐Yes ☐No

15. In the last 10 years, has the Proposed Insured been diagnosed with, or treated for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? ☐Yes ☐No

16. Other than as stated in answers to Questions 12-15, has Proposed Insured, within the last 5 years:

a. Had symptoms of or been treated for dizziness, fainting, shortness of breath, chronic headaches, chronic swelling, palpitation, blood spitting, intestinal bleeding, hemorrhoids, kidney stones, sugar, protein or blood in the urine? ☐Yes ☐No

b. Consulted or been treated by a physician or practitioner, or treated at a hospital, clinic, or other medical facility for any reason? ☐Yes ☐No

c. Had any illness, injury or surgery? ☐Yes ☐No

d. Had electrocardiogram, x-ray, or other diagnostic test (including lab tests)? ☐Yes ☐No

e. Been advised to have any diagnostic test, treatment or surgery which has not been completed? ☐Yes ☐No

17. Are there any medications (prescription or non-prescription) not listed in the details section of questions 12-16 that the Proposed Insured is currently taking? ☐Yes ☐No

18. In the last 10 years has Proposed Insured:

a. Used, except as legally prescribed by a physician, tranquilizers, barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood altering drugs; heroin, methadone or other narcotics; amphetamines or other stimulants; or any other illegal or controlled substances? ☐Yes ☐No

b. Received counseling or treatment regarding the use of alcohol or drugs including attendance at meetings or membership in any self-help group or program such as Alcoholics Anonymous or Narcotics Anonymous? ☐Yes ☐No

19. a. Does the Proposed Insured currently consume alcoholic beverages? ☐Yes ☐No

Type _____Number of Drinks_____ per ☐Day ☐ Week

Type _____Number of Drinks_____ per ☐Day ☐Week

b. If "No," has the Proposed Insured ever consumed alcoholic beverages? ☐Yes ☐No

c. If "Yes," please provide: Date last used_____ (mm/dd/yyyy)

Reason stopped_____

SECTION C-MEDICAL INFORMATION FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

DEATIALS

List details to all "Yes" answers on pages 1 and 2.

Question No./ Letter	Name, Address and Phone Number of Health Professional or facility consulted or seen (Include City & State)	Date of Diagnosis (mm/dd/yyyy) and Duration of Illness	Diagnosis/Treatment/Medication

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SECTION C –FINANCIAL QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Complete SECTION I only if the Proposed Insured is [under age 65] and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals [$2 million or more].

Complete SECTIONS I and II if the Proposed Insured is [age 65 or older] and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals [$1 million or more].

Provide responses for each Proposed Insured and each Owner(s), as well as each Beneficiary, where applicable. (If additional space is needed, attach additional sheet(s) of paper, which must be signed and dated by the Proposed Insured, Owner, and Financial Professional(s)).

Name of Proposed Insured_____ Policy # (if known)_____ Date of Birth_____
(mm/dd/yyyy)

SECTION I PERSONAL FINANCIAL STATEMENT OF THE PROPOSED INSURED(S)

1. Balance Sheet

Assets	
Description	Amount
Cash	$
Stocks, Bonds, Securities	$
Real Estate (including primary residence)	$
Retirement Plans	$
Business Equity	$
Other (please specify)	$
Other (please specify)	$
Total	$

Liabilities	
Description	Amount
Mortgages	$
Loans	$
Notes	$
Other (please specify)	$
Other (please specify)	$
Other (please specify)	$
Other (please specify)	$
Total	$
Net Worth (total assets – total liabilities)	$

2. Income

	Earned Income	Unearned Income				
	Income	Dividends/Interest	Rental Income	Pension/Social Sec.	Other (please specify)	Total
Current Year	$	$	$	$	$	$
Last Year	$	$	$	$	$	$

3. How was the proposed face amount determined for this application?
State what formula was used (e.g., estate tax calculation, survivor needs, estimated fair market value or book value of the business, capitalization of earnings, etc.); if none, state "None"_____

4. Do you expect any changes greater than 15% in income or net worth in the next 12 months? □ Yes □ No
If "Yes," please explain _____
_____

SECTION II (CONT'D on NEXT TWO PAGES) OTHER INFORMATION

"Parties" refers to the following: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy, and/or the Owner of any legal entity owning the policy.

5. Have any of the Parties been offered or promised any incentive (financial or otherwise) as an inducement to apply for or purchase the proposed policy, such as (but not limited to), zero cost or no cost life insurance or cash payments? □Yes □ No

6. Has any compensation or other inducement (including cash, offers or discussions of free insurance, any forgiveness or potential forgiveness of any debt, or other benefits) been discussed or offered directly or indirectly to any of the following in connection with the application for the purchase of this policy: the Proposed Insured, the Owner or Beneficiary, the Beneficiary of any Trust owning the policy, and/or the owner of any legal entity owning the policy, or is there any expectation of receiving any such compensation or inducement? □ Yes □ No
If "Yes," please state the compensation or inducement that will be received or could be received and by whom.
_____
_____
_____

7. Do any of the Parties intend to use or transfer the policy for any type of pre-death financial settlement, such as a viatical settlement, senior settlement, life settlement, or for any other settlement in the secondary market? □ Yes □ N o

SECTION II (CONT'D FROM PREVIOUS PAGE)
OTHER INFORMATION

8. Will any other person or entity (i.e., a person or entity different than the Owner or Beneficiary initially named in the policy) provide any funding, financing, or guarantees for any premium payment on the policy or are any potential or alternate sources of funding, financing, or guarantees under consideration? □ Yes □ No
If "Yes," please submit a copy of all actual or potential funding, financing, or guarantee documents, and a detailed, third party prepared Personal Financial Statement signed by the preparer. The above documents are not required if funding is part of a split-dollar arrangement (1) between the employer and the employee or a corporation and its shareholders, provided that the employment and/or shareholder relationship was not entered into to establish a premium funding arrangement; or (2) between the Proposed Insured and another family member (i.e., in either case, there is no third party unaffiliated entity or non-related individual involved).
Please also answer the following questions:

a. State why the premiums will or may be funded or financed or why other guarantees will or may be provided.

_____
_____
_____

b. State the name of the other person or entity providing the actual or potential funding, financing, or guarantees and role (i.e., lender, guarantor, etc.).

_____
_____
_____

c. State how the actual or potential funding, financing, or guarantees will be repaid, what collateral will be used, and whether the lender's or guarantor's ability to recover is limited to the value of the policy.

_____
_____
_____

d. Will a letter of credit or personal guarantee be posted? □ Yes □ No
If "Yes," please state the details, including details relating to the assets backing the letter of credit.

_____
_____
_____

9. Will any of the Parties have the right or option to transfer any direct or indirect interest in the policy to another person or entity at a predetermined price or other terms? □ Yes □ No
If "Yes," please identify the right or the option and submit a copy of all documents providing for that right or option.

_____
_____
_____

10. a. Will a trust, partnership, or other entity receive or potentially receive any direct or indirect ownership, death benefits, or other interests or benefits in the policy? □ Yes □ No
If "Yes," please submit a copy of all documents that create the trust, partnership, or other entity. The above documents are not required if funding is part of a split-dollar arrangement (1) between the employer and the employee or a corporation and its shareholders, provided that the employment and/or shareholder relationship was not entered into to establish a premium funding arrangement; or (2) between the Proposed Insured and another family member (i.e., in either case, there is no third party unaffiliated entity or non-related individual involved).

b. If an employer sponsored split dollar arrangement, please indicate the amount of time the employee or shareholder has been affiliated with the entity: _____ years

11. Has there been any consideration or any written information provided regarding the sale or transfer or potential sale or transfer to another person, partnership, or other entity of (1) any interest in this policy; or (2) any interest in a trust or other entity that has an interest in this policy? □ Yes □ No
If "Yes," please state what has been considered or provided, what action has or may be taken in the future as a result, and attach the written information provided.

_____
_____
_____

SECTION II (CONT'D FROM PREVIOUS PAGE)

12. Have any of the Parties sold or transferred any life insurance policy or an interest therein, within the last five years? □ Yes □ No
If "Yes," please state the details of the transaction including name of each company and the number of years the policy was in effect.

_____
_____
_____

13. Has any entity, other than the Company checked on page 1 above section A of the Application, medically evaluated the Proposed Insured to determine life expectancy or will such an evaluation occur? □ Yes □ No
If "Yes," please state who has conducted or will conduct the examination, and when the examination occurred or will occur.

_____
_____
_____

REFERENCES

Please complete this References section if:
the Proposed Insured is[under age 70] and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals [$10 million or more];
or
the Proposed Insured is [age 70 or older] and the sum of the Face Amount(s) of *all* concurrent and/or pending applications with the Company checked on page 1 above section A of the Application and/or any other affiliated companies equals [$5 million or more].

□ Attorney □ Accountant

_____
Name, Title Business Address Telephone No.

Has the above-named reference been authorized to release information? □ Yes □ No
If "No," please explain _____
_____
_____

If you did not provide a reference, please explain _____
_____
_____

CERTIFICATIONS

State laws prohibit intentional misstatements in connection with any application for insurance. If you make any misstatement in response to the questions in this Financial Questionnaire (including any intentional misstatement regarding the actual or potential funding of premiums, or transfer or sale of this policy), you will be subject to those laws and any penalties that may result.

I (We), as Proposed Insured and Owner, represent that if I (we) enter into any transaction at any time to assign, sell, or otherwise transfer any interest in the policy or any interest in a trust or other entity owning the policy:
(1) I (We) have not relied on any representations by the Company checked on page 1 above section A of the Application, and/or any other affiliated companies, or its Agents/Insurance Brokers, regarding the benefits and risks of such a transaction; and
(2) there are no guarantees that I (we) will be successful and I (we) may incur costs or other disadvantages and risks of such a transaction. The disadvantages and risks of such a transaction include, but are not limited to, the risk of tax consequences, the loss of death benefits, the loss of insurability, or the loss of other rights or interests that I (we) are not aware of.

If additional sheets of paper are attached to this Financial Questionnaire, please indicate the number of additional pages: _____ pages

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C—CHILDREN'S TERM INSURANCE RIDER QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Name of Proposed Insured_____ Date of Birth_____(mm/dd/yyyy) Policy # (If known)_____

Amount $_____

NAME OF CHILDREN TO BE INSURED

1. List all children proposed for insurance
Only the natural children, legally adopted children, or stepchildren of the person listed in question 1 of section A of the Application who have not reached their 18th birthday are eligible for coverage.

Name and Gender of Child	Date of Birth (mm/dd/yyyy)	Height/Weight	Relationship to Proposed Insured	Name, Address and Phone No. of Primary Care Physician
First: Middle: Last: Gender: ☐Male ☐Female				
First: Middle: Last: Gender: ☐Male ☐Female				
First: Middle: Last: Gender: ☐Male ☐Female				
First: Middle: Last: Gender: ☐Male ☐Female				

MEDICAL HISTORY

List details of all "Yes" answers to Questions 2, 3 and 4 in chart on page 2

2. Has any child proposed for insurance ever had a driver's license suspended or revoked or, within the last 5 years, been convicted of, or cited for any moving violations for driving under the influence of alcohol or drugs? ☐Yes ☐No

3. Has any child proposed for insurance:

a. Ever been diagnosed with, treated for, or had symptoms of asthma, diabetes, cancer or tumor, or any disorder of the heart or blood vessels, including heart murmur? ☐Yes ☐No

b. In the last 5 years, consulted a physician, or been examined or treated at a hospital or other medical facility? (Include medical checkups in the last 2 years. Do not include colds or minor injuries.) ☐Yes ☐No

c. In the last 10 years:

i. Used, except as legally prescribed by a physician, tranquilizers, barbiturates or other sedatives; marijuana, cocaine, hallucinogens or other mood-altering drugs; heroin, methadone or other narcotics; amphetamines or other stimulants; or any other illegal or controlled substances? ☐Yes ☐No
(If "Yes," complete Substance Usage Questionnaire)

ii. Received counseling or treatment regarding the use of alcohol or drugs including attendance at meetings or membership in any self-help group or program such as Alcoholics Anonymous or Narcotics Anonymous? ☐Yes ☐No
(If "Yes," complete Substance Usage Questionnaire)

d. In the last 10 years, been diagnosed with, or treated for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by a member of the medical profession? ☐Yes ☐No

4. Is any child proposed for insurance receiving special training because of physical or mental disability, or unable to participate actively at work, or in school, or to perform normal activities? ☐Yes ☐No

DETAILS

5. List details of all ''Yes'' answers to Questions 2,3 and 4. (Use remarks section if additional space is needed)

Name of Child	Date of Diagnosis (mm/dd/yyyy) Duration of Illness	Diagnosis/Treatment/Medication/ Restrictions in Activity	Name, Address and Phone Number of Health Professional or facility consulted or seen (Include City & State)

COVERAGE AND PREMIUM CHARGE NOTICE

The Owner of this Rider is the Owner of the life insurance policy unless otherwise specified in the Remarks section of the Application.

I (We) understand that the coverage provided under the Children's Term Insurance Rider terminates for each eligible child the earliest of: the termination of the policy; when he/she reaches age 25; and the day before the policy anniversary nearest the Proposed Insured's 65th birthday. This coverage applies to all children I (we) currently have, and may have (or adopt) in the future. Because AXA Equitable (or the Insurance Company checked on page 1 above section A of the application does not have any means of knowing how many children I (we) may have (or adopt) in the future, I (we) understand that AXA Equitable (or the Insurance Company checked on page 1 above section A of the application and/or any other affiliated companies will continue to charge for this rider until the policy anniversary nearest the Proposed Insured's 65th birthday. I (We) also understand that if I (we) have no children under age 25 and want to terminate this rider, I (we) must notify AXA Equitable (or the Insurance Company checked on page 1 above section A of the application and/or any other affiliated companies in writing.

REMARKS

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C-- SUBSTANCE USAGE QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Name of Proposed Insured _____ Date of Birth_____ Policy # (If known)_____
(mm/ddd/yyyy)

SUBSTANCE USEAGE

1. Do you currently use or have you ever used:

a. Alcohol? ☐Yes ☐No
b. Marijuana? ☐Yes ☐No
c. Heroin, morphine, or other narcotic drug? ☐Yes ☐No
d. Cocaine, crack? ☐Yes ☐No
e. Barbiturates, sedatives, or tranquilizers? ☐Yes ☐No
f. Amphetamines? ☐Yes ☐No
g. LSD, or any other hallucinogens? ☐Yes ☐No
h. Other_____

DETAILS

2. Details of any ''Yes'' answers to 1 a-h

Type	Amount Used	Frequency (daily, weekly, monthly, yearly)	Dates Used

SUBSTANCE USAGE

3. Have your substance usage habits lessened? ☐Yes ☐No
*If "Yes," provide details and include when and why they changed:*_____

4. Have you ever consulted a physician or psychologist or received counseling or treatment for substance usage? ☐Yes ☐No
If ''Yes,'' provide details of all counseling or treatments, including dates, length of treatment, name and address of physician, counselor or facility:

5. Do you currently use, or have you used alcohol or drugs since your last treatment for substance usage? ☐Yes ☐No
If ''Yes,'' provide details including dates of each occurrence:

6. Have you ever been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar organization? ☐Yes ☐No

If ''Yes,'' a. Name of Organization _____
b. Date first attended _____ d. Date last attended_____
c. Are you currently active? ☐ Yes ☐No e. How often do you attend meetings?_____

7. Have you ever been charged with driving while intoxicated or driving under the influence? ☐Yes ☐No
If ''Yes,'' provide details including date, city and state of each occurrence:

8. Please add any additional information that may be relevant to our evaluation:

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C-- AVIATION QUESTIONNNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Name of Proposed Insured_____ Date of Birth_____ (mm/dd/yyyy) Policy # (if known)_____

LICENSING, RATING AND FAA MEDICAL

1. Have you in the last year, flown as a pilot, student pilot, or crewmember on any type of aircraft? ☐Yes ☐No
   If "Yes," date of last flight as pilot _____ (mm/dd/yyyy)
2. Type of aviation license or certificate ☐Student ☐Private ☐Commercial ☐Other_____
   Date of Issue _____ (mm/dd/yyyy)
3. Do you have an Instrument Flight Rating? ☐Yes ☐No
4. Class of FAA medical certificate _____ Date of last FAA medical examination_____ (month/year)

TYPE OF FLYING

5. Include all types

	Type of aircraft flown	Hours last 12 months	Contemplated hours next 12 months
Student			
Pleasure			
Personal Business			
Scheduled Airline, Including Air Taxi or Commuter			
Non-scheduled Passenger or Freight			
Employer Owned Aircraft			
Student Instruction			
Active Military			
National Guard or Reserve			
Crewmember			
* Other, Specify_____			

*Provide full details of any other flying not specifically classified above (advertising, construction, crop dusting, fire fighting, inspection (pipe, power, telephone line), mapping, medical airlifting and evacuation, oil and natural gas exploration, photography, police and law enforcement, testing, traffic control, weather patrol, hang gliding, gliding, ballooning, etc.)

CIVILIAN FLYING

6. Total number of hours flown as a pilot_____
7. Are flights made only between established airports? ☐Yes ☐No *If "No," explain* _____
8. Have you flown or do you intend to fly an experimental, ultralight, personally built or assembled, or prototype aircraft? ☐Yes ☐No
   If "Yes," provide details _____
9. Have you ever been grounded, had any flying accidents, had a written violation or had your license suspended or revoked? ☐Yes ☐No
   If "Yes," please include dates and full details regarding the circumstances surrounding the infraction. If it was an accident, please include details regarding the extent of personal injury and/or damage to the aircraft(s).

   _____
10. Please provide any additional information that may be relevant to our evaluation_____

    _____

COVERAGE PREFERENCE

Select Only One

11. If either is necessary under Company rules, which of the following do you prefer?
    ☐Full Aviation coverage at an extra premium

    ☐Restricted Coverage without extra premium

OTHER AVIATION ACTIVITIES

Please provide details regarding any other aviation activities in which you participate

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C--AVOCATION QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE *Complete all section(s) that apply*

Name of Proposed Insured _____ Date of Birth _____ (mm/dd/yyyy) Policy # (if known) _____

DIVING

1. Type or purpose of diving ☐Recreation ☐Instruction ☐Construction ☐Salvage ☐Search Work ☐Cave Diving ☐Other _____
2. Location in which you dive ☐Deep Sea/Ocean ☐Other _____
3. Type of certification held _____ Date of certification _____ (mm/dd/yyyy) Equipment used _____
4. Do you ever dive alone? ☐Yes ☐No 5. Check appropriate box ☐ Skin or scuba diving ☐ Diving other than skin or scuba
6. Diving activity

	Past 12 months		Contemplated next 12 months	
Depths of dives	Number of dives	Average time per dive	Number of dives	Average time per dive
0-75 feet				
76-100 feet				
101-150 feet				
Over 150 feet				

RACING

7. Status ☐Professional ☐Amateur ☐Other _____
8. Do you hold a competition driver's license from any organization? ☐Yes ☐ No
   If "Yes," list all organizations _____
9. Type of racing ☐Stock Car ☐Sports Car ☐Sprint Car ☐Midget ☐Formula Car ☐Championship ☐Drag Elapsed Time ___ seconds ☐All-terrain ☐Motorcycle ☐Powerboat ☐Snowmobile ☐Other _____
10. Vehicle a. Make _____ b. Model _____ c. Horsepower _____ d. Engine displacement (cc) _____
11. Course Type a. ☐Paved Track ☐Dirt Track ☐Desert/Off road ☐Drag Strip ☐Road Course ☐Cross-country ☐Hill Climbing ☐Other _____
    b. Length of course _____ c. Length of race _____
12. Speed a. Maximum speed attained (mph) _____ b. Average speed _____
13. Number of races a. Last 12 months _____ b. Contemplated next 12 months _____

JUMPING

☐ PARACHUTING OR ☐ SKYDIVING OR ☐ HANG GLIDING

14. Status ☐Professional ☐Amateur ☐Other _____
15. Do you belong to an organized club? ☐Yes ☐No *If "Yes," name of club* _____
16. Number of jumps a. Last 12 months _____ b. Contemplated next 12 months _____ c. Total number of jumps to date _____
17. Type of jumps (stunting, instructional, BASE, etc.) _____
18. Over what type of terrain are jumps made? _____

CLIMBING

☐ MOUNTAIN CLIMBING OR ☐ ROCK CLIMBING

19. Type of climbing ☐Trail ☐Ice ☐Rock ☐Glacier ☐Snow
20. Type of training _____ Years of experience _____
21. Do you belong to an organization? ☐Yes ☐No *If "Yes," name of organization* _____
22. Equipment used _____
23. Number of climbs a. Last 12 months _____ b. Contemplated next 12 months _____ c. Total number climbs to date _____

Climbing Details

Date (mm/dd/yyyy)	Type (mountain, rock, ice, etc.)	Level or Class (A1-A5, 1-6 etc.)	Elevation (specify feet or Meters)	Location (Mountain range, State, Country)

OTHER ACTIVITIES

Please provide details regarding any other avocation activities in which you participate

AXA Equitable Life Insurance Company MONY Life Insurance Company of America

SECTION C—TERM/TERM RIDER CONVERSION & PURCHASE OPTION QUESTIONNAIRE FORMING PART OF THE APPLICATION FOR LIFE INSURANCE

Complete on Term Policy/Rider Conversion, Option to Purchase Additional Insurance if the Purchase Option or term conversion to the permanent contract involves an increase in face amount, change in rating or addition of new rider.

Name of Proposed Insured_____ Date of Birth_____ (mm/dd/yyyy) Policy # (If known)_____

TERM CONVERSION

a. Original policy #s _____ _____ _____

b. Are you currently disabled? ☐Yes ☐No

c. Is original policy attached? ☐Yes ☐No If "No," is original policy lost? ☐Yes ☐No

OPTION TO PURCHASE ADDITIONAL INSURANCE ELECTION

a. Original policy #s _____ _____ _____

b. Check appropriate box, and/or provide information as requested:

i. ☐Scheduled Purchase Option ☐Advanced Privilege/Option B or C (at time other than the scheduled Option date)
ii. Option date used _____ (mm/dd/yyyy)

Complete only if the Advanced Privilege/Option B or C box is checked.

iii. Event
☐Marriage Date_____ (mm/dd/yyyy) Name of Spouse_____

☐Birth or finalized legal adoption of child

Name of child_____ Born_____ (mm/dd/yyyy) Date of adoption finalized_____ (mm/dd/yyyy)

COMPANY COPY

(Check One) ☐AXA Equitable Life Insurance Company ☐MONY Life Insurance Company of America

LIMITED TEMPORARY INSURANCE AGREEMENT/RECEIPT

Name of Proposed Insured_____ Date of Birth_____(mm/dd/yyyy)

INSTRUCTIONS

If the full initial premium is paid with the Application, and all the questions 39 to 45 in section A of the Application and questions 36 to 41 in the Survivorship Product Questionnaire, if applicable, are answered "no," one original, signed Temporary Insurance Agreement/Receipt must be returned with the application. The other original, signed Temporary Insurance Agreement/Receipt must be left with the Owner(s). If the policy applied for is a survivorship policy, both Proposed Insured(s) and the Owner must sign.

In this Agreement, ''we,'' ''our'' and ''us'' mean the insurance company checked above. We will pay an insurance benefit, upon receipt of all claim documents that we may require at that time, to the beneficiary named in the Application if a person proposed for insurance dies while temporary insurance is in effect. For joint survivorship life insurance policies, the insurance benefit is payable upon the death of the second of the Proposed Insureds to die. Any coverage provided under this Agreement is subject to the conditions stated below. The temporary insurance will be in the amount described below and in accordance with the terms of the policy we would issue.

CONDITIONS

Conditions Precluding Temporary Insurance Coverage: If any of the following applies, no financial professional is authorized to accept payment, and NO INSURANCE WILL TAKE EFFECT UNDER THIS AGREEMENT.

(1) Any of the questions 39 to 45 in section A of the Application or questions 36 to 41 in the Survivorship Product Questionnaire, if applicable, is answered YES or LEFT BLANK.
(2) Any material misstatement made in any part of the Application, any application supplement, questionnaire or in this Agreement.
(3) The amount paid with this Agreement is less than the full initial premium required for the policy, or a properly signed approved payment authorization is not submitted.
(4) The check or withdrawal authorization submitted with this Agreement is dishonored when first presented for payment.

DATE TIA STARTS

Date Temporary Insurance Coverage Starts: Temporary insurance under this Agreement shall not take effect until: (i) we receive the full initial premium, and (ii) a signed Application, and (iii) the later of (a) and (b) has occurred.

a. The date that the Medical Information Supplement is completed, if initially required as to any Proposed Insured(s) by our published underwriting rules (see below).

To be completed by Financial Professional/Insurance Broker: A Medical Information Questionnaire
☐ Is required for Proposed Insured 1 ☐ Is not required for Proposed Insured 1 and
☐ Is required for Proposed Insured 2 ☐ Is not required for Proposed Insured 2

OR

b. The date that Part 2 (Paramedical or Medical exam) is completed, if initially required as to the Proposed Insured(s) by our published underwriting rules (see below).

To be completed by Financial Professional/Insurance Broker: An Application Part 2 (Paramedical or Medical Exam)
☐Is required for Proposed Insured 1 ☐ Is not required for Proposed Insured 1 and
☐Is required for Proposed Insured 2 ☐ Is not required for Proposed Insured 2

If any Proposed Insured dies as a result of accidental bodily injury, directly and independently of all other causes, before a required Medical Information Questionnaire or Application Part 2 (Paramedical or Medical Exam) for that person is completed, then the temporary insurance will be in effect subject to the conditions contained in this Agreement, unless it terminated earlier.

LIMITED AMOUNT

The amount of temporary insurance is the amount of insurance applied for on the life of any Proposed Insured and in effect under all Temporary Insurance Agreements/Receipts issued by the company checked above, and its subsidiaries or affiliates, not to exceed $1,000,000 in total.

DATE TIA COVERAGE ENDS

Date Temporary Insurance Coverage Ends—90-Day Maximum Coverage Period: Temporary insurance under this Agreement will end upon the earliest of:
(1) The date we offer insurance other than as applied for on any Proposed Insured; and
(2) The date the policy takes effect, which is the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; and
(3) The date any policy issued under the Application is refused by the Owner(s); and
(4) Five days after we mail a notice declining the Application and enclosing a refund of any premium paid; and
(5) The 90th day after the date Part 1 of the Application is signed by the Proposed Insured(s) and Owner(s).

CONVERAGE NOT PROVIDED

(1) No coverage is provided under this Agreement for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.
(2) No coverage is provided under this Agreement if Section 1035 paperwork is received without the full initial premium with the Application for the Exchange Contract.
(3) There is no coverage under this Agreement for any death resulting from suicide (while sane or insane). Our liability is limited to return of premium paid.

PREMIUM CHECKS

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY CHECKED ON PAGE ONE. DO NOT MAKE CHECK PAYABLE TO THE FINANCIAL PROFESSIONAL OR LEAVE THE PAYEE BLANK.

Receipt: Received from X_____

$_____ , which is at least the full initial premium required for the policy.
The payment indicated above will be refunded (without interest) if any temporary insurance under this Agreement ends, other than because of death or because the policy has taken effect.

AFFIRMATIONS

In signing below, I (we) agree that I (we) have reviewed all parts of the Application and, as of date below, I (we) affirm that the statement and answers made in all parts of that Application continue to be true and complete to the best of my (our) knowledge and belief. I (We) understand that if the conditions listed in the Agreement are not met, no temporary insurance will take effect. I (We) also understand the provisions contained in this Agreement regarding: (1) the limitation on the amount of temporary coverage provided; (2) when temporary coverage will begin and end; and (3) the coverage that is not provided under this Agreement. I (We) explicitly agree to all of the terms and conditions contained in this Agreement as written and understand that no financial professional, insurance broker or agent has the authority to modify the Application, its supplements or questionnaires or this Agreement, or to bind the company by making any promise or representation contrary to the terms and conditions contained in the Application or this Agreement.

SIGNATURES

I (We), the undersigned, by my (our) signature(s) below agree to all the terms and conditions of the Application, including, but not limited to, the Acknowledgment and Authorization.

X_____ X_____
Signature of Proposed Insured 1 Signature of Proposed Insured 2
(Parent, Guardian, or Applicant if Proposed Insured is a Child, Issue Ages 0−14)

X_____ _____ _____
Signature of Owner or Applicant if not Proposed Insured(s) Signed by Owner at City, State Dated on (mm/dd/yyyy)
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

I am not aware of any other information that would adversely affect Proposed Insured's eligibility for insurance coverage.
On the date of this Agreement, I received the premium amount indicated above. This Agreement bears the same date as the Application Part 1.
I have explained the terms of this Agreement to the Proposed Insured(s) and Owner(s) who has (have) stated to me that she/he (they) understand and accept them.

Signature of Licensed Financial Professional/Insurance Broker X_____

OWNER COPY

(Check One) ☐AXA Equitable Life Insurance Company ☐MONY Life Insurance Company of America

LIMITED TEMPORARY INSURANCE AGREEMENT/RECEIPT

Name of Proposed Insured_____ Date of Birth_____(mm/dd/yyyy)

INSTRUCTIONS

If the full initial premium is paid with the Application, and all the questions 39 to 44 in section A of the Application and questions 36 to 41 in the Survivorship Product Questionnaire, if applicable, are answered "no," one original, signed Temporary Insurance Agreement/Receipt must be returned with the application. The other original, signed Temporary Insurance Agreement/Receipt must be left with the Owner(s). If the policy applied for is a survivorship policy, both Proposed Insured(s) and the Owner must sign.

In this Agreement, "we," "our" and "us" mean the insurance company checked above. We will pay an insurance benefit, upon receipt of all claim documents that we may require at that time, to the beneficiary named in the Application if a person proposed for insurance dies while temporary insurance is in effect. For joint survivorship life insurance policies, the insurance benefit is payable upon the death of the second of the Proposed Insureds to die. Any coverage provided under this Agreement is subject to the conditions stated below. The temporary insurance will be in the amount described below and in accordance with the terms of the policy we would issue.

CONDITIONS

Conditions Precluding Temporary Insurance Coverage: If any of the following applies, no financial professional is authorized to accept payment, and NO INSURANCE WILL TAKE EFFECT UNDER THIS AGREEMENT.

(1) Any of the questions 39 to 45 in section A of the Application or questions 36 to 41 in the Survivorship Product Questionnaire, if applicable, is answered YES or LEFT BLANK.
(2) Any material misstatement made in any part of the Application, any application supplement, questionnaire or in this Agreement.
(3) The amount paid with this Agreement is less than the full initial premium required for the policy, or a properly signed approved payment authorization is not submitted.
(4) The check or withdrawal authorization submitted with this Agreement is dishonored when first presented for payment.

DATE TIA STARTS

Date Temporary Insurance Coverage Starts: Temporary insurance under this Agreement shall not take effect until: (i) we receive the full initial premium, and (ii) a signed Application, and (iii) the later of (a) and (b) has occurred.

c. The date that the Medical Information Supplement is completed, if initially required as to any Proposed Insured(s) by our published underwriting rules (see below).

To be completed by Financial Professional/Insurance Broker: A Medical Information Questionnaire
☐ Is required for Proposed Insured 1 ☐ Is not required for Proposed Insured 1 and
☐ Is required for Proposed Insured 2 ☐ Is not required for Proposed Insured 2

OR

d. The date that Part 2 (Paramedical or Medical exam) is completed, if initially required as to the Proposed Insured(s) by our published underwriting rules (see below).

To be completed by Financial Professional/Insurance Broker: An Application Part 2 (Paramedical or Medical Exam)
☐Is required for Proposed Insured 1 ☐ Is not required for Proposed Insured 1 and
☐Is required for Proposed Insured 2 ☐ Is not required for Proposed Insured 2

If any Proposed Insured dies as a result of accidental bodily injury, directly and independently of all other causes, before a required Medical Information Questionnaire or Application Part 2 (Paramedical or Medical Exam) for that person is completed, then the temporary insurance will be in effect subject to the conditions contained in this Agreement, unless it terminated earlier.

LIMITED AMOUNT

The amount of temporary insurance is the amount of insurance applied for on the life of any Proposed Insured and in effect under all Temporary Insurance Agreements/Receipts issued by the company checked above, and its subsidiaries or affiliates, not to exceed $1,000,000 in total.

DATE TIA COVERAGE ENDS

Date Temporary Insurance Coverage Ends—90-Day Maximum Coverage Period: Temporary insurance under this Agreement will end upon the earliest of:
(1) The date we offer insurance other than as applied for on any Proposed Insured; and
(2) The date the policy takes effect, which is the date the policy and all amendments are delivered to the Owner(s) and all delivery requirements have been completed; and
(3) The date any policy issued under the Application is refused by the Owner(s); and
(4) Five days after we mail a notice declining the Application and enclosing a refund of any premium paid; and
(5) The 90th day after the date Part 1 of the Application is signed by the Proposed Insured(s) and Owner(s).

CONVERAGE NOT PROVIDED

(1) No coverage is provided under this Agreement for a policy or benefit applied for under the terms of a guaranteed insurability option or a conversion privilege.
(2) No coverage is provided under this Agreement if Section 1035 paperwork is received without the full initial premium with the Application for the Exchange Contract.
(3) There is no coverage under this Agreement for any death resulting from suicide (while sane or insane). Our liability is limited to return of premium paid.

PREMIUM CHECKS

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY CHECKED ON PAGE ONE. DO NOT MAKE CHECK PAYABLE TO THE FINANCIAL PROFESSIONAL OR LEAVE THE PAYEE BLANK.

Receipt: Received from X_____

$_____ , which is at least the full initial premium required for the policy.
The payment indicated above will be refunded (without interest) if any temporary insurance under this Agreement ends, other than because of death or because the policy has taken effect.

AFFIRMATIONS

In signing below, I (we) agree that I (we) have reviewed all parts of the Application and, as of date below, I (we) affirm that the statement and answers made in all parts of that Application continue to be true and complete to the best of my (our) knowledge and belief. I (We) understand that if the conditions listed in the Agreement are not met, no temporary insurance will take effect. I (We) also understand the provisions contained in this Agreement regarding: (1) the limitation on the amount of temporary coverage provided; (2) when temporary coverage will begin and end; and (3) the coverage that is not provided under this Agreement. I (We) explicitly agree to all of the terms and conditions contained in this Agreement as written and understand that no financial professional, insurance broker or agent has the authority to modify the Application, its supplements or questionnaires or this Agreement, or to bind the company by making any promise or representation contrary to the terms and conditions contained in the Application or this Agreement.

SIGNATURES

I (We), the undersigned, by my (our) signature(s) below agree to all the terms and conditions of the Application, including, but not limited to, the Acknowledgment and Authorization.

X_____ X_____
Signature of Proposed Insured 1 Signature of Proposed Insured 2
(Parent, Guardian, or Applicant if Proposed Insured is a Child, Issue Ages 0−14)

X_____ _____ _____
Signature of Owner or Applicant if not Proposed Insured(s) Signed by Owner at City, State Dated on (mm/dd/yyyy)
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

I am not aware of any other information that would adversely affect Proposed Insured's eligibility for insurance coverage.
On the date of this Agreement, I received the premium amount indicated above. This Agreement bears the same date as the Application Part 1.
I have explained the terms of this Agreement to the Proposed Insured(s) and Owner(s) who has (have) stated to me that she/he (they) understand and accept them.

Signature of Licensed Financial Professional/Insurance Broker X_____

AXA EQUITABLE

☐ AXA Equitable Life Insurance Company
☐ MONY Life Insurance Company of America

TERM POLICY/RIDER CONVERSION OR PURCHASE OPTION APPLICATION

[1290 Avenue of the Americas, New York, NY 10104]

"AXA Equitable" is the brand name of AXA Equitable Financial Services, LCC and its family of companies, including AXA Equitable Life Insurance Company and MONY Life Insurance Company of America.

Not for use if conversion involves an increase in face amount, change in rating or addition of new riders.

Original Policy Number(s) _____ _____ _____

New Plan Type _____ New Face Amount _____

Complete and attach Section B-Product Information for New Plan

Is (are) the original policy(ies) attached? ☐Yes ☐No If "No," is (are) the original policy(ies) lost? ☐Yes ☐No

TYPE OF CONVERSION/PURCHASE OPTION REQUEST

☐ Full Conversion (Entire amount of Term policy being converted)
☐ Partial Term Conversion (If allowed, balance of term coverage remaining after conversion to be continued with premium payment corresponding to remaining coverage only if the term coverage remaining meets minimum requirements.)
☐ Partial Term Conversion (Term coverage remaining after conversion to be discontinued)
☐ Term Rider Conversion
☐ Term Dividend Conversion
☐ Option to Purchase Additional Insurance (Purchase Option)

Check appropriate box and/or provide information as requested

i. ☐Scheduled Purchase Option ☐Advanced Privilege/Option B or C (at time other than the scheduled Option date)

ii. Option date used _____ (mm/dd/yyyy)

Complete only if the Advanced Privilege/Option B or C box is checked.

iii. Event

☐Marriage Date_____ (mm/dd/yyyy) Name of Spouse_____

☐Birth or finalized legal adoption of child

Name of child_____ Born_____ (mm/dd/yyyy) Date of finalized adoption _____ (mm/dd/yyyy)

If there are unearned premium(s) on the Term contract, would you like the unearned premium(s):

☐ Applied to the new contract Or ☐ Refunded to the Owner(s) of the Term contract?

INSURED

1. Name First _____ Middle _____ Last _____
2. Sex ☐ Male ☐ Female 3. Date of birth_____ (mm/dd/yyyy)
4. SSN_____ 5. Are you currently disabled? ☐ Yes ☐ No
6. Primary residential address_____Bldg/Apt/Suite_____

City/Municipality_____ County/Parish*_____ State _____ Zip _____

**County/Parish required in AL, FL, GA, KY, LA and SC.*

BENEFICIARY INFORMATION

7. If no contingent beneficiary is named, the contingent beneficiary will be: (1) the Insured's surviving children, if any, in equal shares; or (2) if the Insured has no surviving children, the contingent beneficiary will be the Insured's estate.
Total percentage must equal 100% for each category of beneficiary. If percentage shares are left blank, the shares will be deemed equal.
If beneficiary is a Trust (other than Owner), include full name and date of Trust.

Full Name	Relationship to Insured	Beneficiary Type	(%) (Percentage)
		☐Primary ☐Contingent	
		☐Primary ☐Contingent	
		☐Primary ☐Contingent	

OWNER INFORMATION

8a. Is the Insured the Owner? ☐Yes ☐ No (If "No," complete questions 8b, and 9)

8b. Owner Name_____ Date of Birth _____ (mm/dd/yyyy) SS#_____

9. Address:_____
No. & Street City State Zip Code

10. Email address of owner as stated in 8a or 8b _____

OTHER INSURANCE

11. Including any policies and riders with the Company checked on page 1, its affiliates and any other life insurance company:
    a. Do you have any life insurance / annuities currently in force, including any policy that has been sold, settled or assigned to or with a settlement or viatical company or any other person or entity? ☐Yes ☐No
    b. Will the coverage applied for replace, change, or affect any existing policy(ies) or contract(s)? ☐Yes ☐No

Complete as appropriate if either question 11a or b is "Yes" (Use remarks section if additional space is needed)

Name of Company	Total Amount (Face Plus Riders)	Year Issued	Policy/ Contract #	P-Personal G-Group B-Business A-Annuity	To Be Replaced Changed or Affected	1035 Exchange
				☐ P ☐ B ☐ G ☐ A	☐Yes ☐ No	☐Yes ☐ No
				☐ P ☐ B ☐ G ☐ A	☐Yes ☐ No	☐Yes ☐ No

MILITARY SERVICE

12 Are you a member of the armed forces, including the reserves? ☐Yes ☐No

(If "Yes," you must also submit a completed and signed Life Insurance/Annuity Disclosure to Active Duty Members of the Armed Forces)

REMARKS

If additional space is needed, attach additional sheet(s) of paper with your name and signature.

AGREEMENT/ACKNOWLEDGEMENT

The Owner(s) agree(s) that:

(1) For Term Policy or Term Rider conversion, this application and any new policy is contingent on the cancellation of coverage for the same amount under the term policy or term rider.
(2) No insurance will be in effect under this request, or under any new policy issued by the Company checked on page 1, unless or until the policy has been delivered and accepted and the first full modal premium for the issued policy has been paid.
(3) The respective period for incontestability or suicide exclusion will be the same as the remaining period on the term life insurance policy or the policy from which the term rider is to be converted, if any.
(4) No financial professional has authority to modify this Agreement and/or waive any of our rights and/or requirements. The Company checked on page 1 shall not be bound by any information unless it is stated in this Application.
(5) I (We) acknowledge receipt of the Living Benefits Brochure (Accelerated Death Benefit Rider Brochure), where applicable.
(6) If applicable, I (we) as the trustee(s) represent(s) that the Trust named as Owner is allowed to purchase life insurance and securities under the Trust document. I (We)further represent that beneficial interests in the Trust are only for parties who are related closely by blood or law, and who have a substantial interest in the Insured engendered by love and affection, or those who have a lawful and substantial economic interest in the continued life of the Insured.
(7) I (We) represent and certify to the Company checked on page 1that none of the monies utilized to fund this policy derived directly or indirectly from illegal activities or sources and/or tax evasion.

AUTHORIZATION IF BANK DRAFT IS ELECTED

I (We) request and authorize the Company checked on page 1 to charge my (our) checking account to pay premiums due under the policy(ies). It is understood that debits will be made automatically after the effective date determined by the Company checked on page 1 and if charges are overlooked or inadvertently not made, the Company checked on page 1 may charge my (our) account at a later date for these missed charges provided the policy(ies) is active. I (We) understand that the use of the Bank Draft Payment Plan does not change any policy provision. I (We) understand this authorization is to remain in full force and in effect, unless terminated. I (We) understand this Plan may be terminated by the depositor, the Owner or the Company checked on page 1 upon 30 days written notice to the other parties or if any charge due is not paid or is reversed by the Bank. I (We) understand this Plan may be terminated upon closing of my (our) bank account. I (We) understand if this Plan is terminated, premiums for regular or scheduled premium policies will be payable directly to the Company checked on page 1. I (We) agree that this Plan may be terminated if any debit is not honored by my (our) Bank or Depository for any reason. I (We) further agree that if any such charge is dishonored, whether with or without cause and whether intentionally or inadvertently, that the Company checked on page 1 shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under the penalties of perjury, I(we) certify that (i) the number showing on this form is my (our) correct Taxpayer Identification Number (Social Security Number, Employer Identification Number or other Taxpayer Identification Number), and (ii) I(we) am(are) not subject to backup withholding because (A) I (We) am (are) exempt from backup withholding or (B) I (We) have not been notified by the Internal Revenue Service (IRS) that I (we) am (are) subject to backup withholding as a result of a failure to report all interest or dividends or (C) the IRS has notified me that I (we) am (are) no longer subject to backup withholding and (iii) I (we) am (are) a U.S. person (including a U.S. resident alien).
Certification Instructions: You must cross out item (ii) above if you have been notified by the Internal Revenue Service that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return.
The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

STATE FRAUD DISCLOSURES

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING AN INTENTIONALLY FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

ARKANSAS AND DISTRICT OF COLUMBIA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

ACKNOWLEDGMENTS

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PLEASE INDICATE YOU HAVE REVIEWED THE QUESTIONNAIRES AS THEY HAVE BEEN COMPLETED BY CHECKING THE APPROPRIATE BOX(ES) BELOW. FAILURE TO CHECK THE APPROPRIATE BOX(ES) WILL REQUIRE YOU TO SIGN AN APPLICATION AMENDMENT.

Section B-Product Information (must select at least 1 product)

[☐Universal Life (Athena UL)
☐Indexed Universal Life (Athena IUL)
☐Variable Universal Life (IL Optimizer II)
☐Interest Sensitive Whole Life (ISWL)
☐Variable Universal Life (IL Legacy II)
☐Survivorship Universal Life (ASUL III)
☐Survivorship Variable Universal Life (SIL Legacy)
]

SIGNATURES

I (We), the undersigned agree that the statements and answers in all parts of the Application and any application questionnaires checked above are true and complete to the best of my (our) knowledge and belief. Further, I (we) understand that I am (we are) agreeing to all the terms and conditions of this application.

_____ _____ _____
Signature of Owner(s) Signed by Owner(s) in City, State Dated on (mm/dd/yyyy)
(If corporation, print firm's name, signature and title of authorized officer.)
(If Trust, signature of trustee.)

FINANCIAL PROFESSIONAL TO COMPLETE THIS SECTION

I certify that I have asked and recorded completely and accurately the answers to all questions on this fully completed Application.

For VUL Policies Only:
Based on the information furnished by the Owner in this and any other part of the application(s), I certify that I have reasonable grounds for believing the purchase of the policy applied for is suitable for the applicant or the owner. I further certify the current prospectuses were delivered and that no written sales materials other than those furnished by the Company checked on page 1 were used.

Signature of Licensed Financial Professional/Insurance Broker_____Dated on _____(mm/dd/yyyy)

Print Licensed Financial Professional's Name/Insurance Broker Name_____ _____

SERFF Tracking Number:	*ELAS-127186217*	*State:*	*Arkansas*
Filing Company:	*MONY Life Insurance Company of America*	*State Tracking Number:*	*49042*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*Life Insurance Applications/AXA-Life-2011*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attached is our signed readability certification.

Attachment:

MLOA Readability Certification -- AR -- PRF.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: We are not using a third party to assemble or submit this filing.

Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attached our Statment of Variability.

Attachment:

Statement of Variability AR -- PRF.pdf

MONY Life Insurance Company of America

CERTIFICATION OF READABILITY

MONY Life Insurance Company of America has reviewed the enclosed forms and certifies that these forms meet the minimum Flesch Scale Readability requirements.

FORM NO.	SCORE
AXA-Life-2011AR	51.88
AXA-Term-2011	53.43
AXA-ILLeg-2011 (PRF)	51.12
AXA-LTC-2011	64.90
AXA-OWNR-2011	63.41
AXA-FRN-2011	64.06
AXA-MED-2011	56.63
AXA-FIN-2011	50.05
AXA-CTR-2011	53.76
AXA-SUB-2011	56.73
AXA-AVN-2011	53.34
AXA-AVC-2011	71.82
AXA-TCPO-2011	62.35
AXA-TIA-2011	50.62
AXA-TCONV-2011	51.88

BY: 

Signature

John R. Finneran

Name

Assistant Vice President

Title

June 10, 2011

Date

AXA EQUITABLE LIFE INSURANCE COMPANY
MONY LIFE INSURANCE COMPANY OF AMERICA

STATEMENT OF VARIABILITY

This Statement of Variability describes the bracketed material contained in the below-referenced forms. Variability is denoted by the use of bracketing on the forms. This allows the Company to make the changes in accordance with the statements below without refiling.

Form Number	Form Description
AXA-Life-2011AR	Individual Life Insurance Application

1. **Company Address (page A1 and D1):** We have bracketed the Home Office address, as it may change in the future.

2. **Product Information (page D3):** We have bracketed the list of Product Information questionnaires to account for future changes in our portfolio. We will always get State Department of Insurance (or Interstate Insurance Product Regulation Commission "IIPRC," if applicable in the future) approval for the product types that require approval before we offer them to the public.

3. **Additional Underwriting Requirements (page D3):** We have bracketed the list of Additional Underwriting Requirements questionnaires to account for future underwriting changes. We will always get State Department of Insurance (or IIPRC, if applicable in the future) approval for the specific type of underwriting change.

Form Numbers	Form Description
AXA-Term-2011	Term Life Insurance Questionnaire
AXA-ISWL-2011	Interest Sensitive Whole Life Insurance Questionnaire
AXA-AUL-2011	Flexible Premium Universal Life Insurance Questionnaire
AXA-ASUL-2011	Flexible Premium Survivorship Universal Life Insurance Questionnaire
AXA-ESLI-2011	Flexible Premium Universal Life Insurance Questionnaire

1. **Marketing Name(s):** The marketing name(s) of each product is bracketed to allow for future changes. We will not offer any new product without State Department of Insurance (or IIPRC, if applicable in the future) approval.

2. **Optional Benefits/Riders (and footnotes):** We have bracketed optional benefits to allow for optional benefit riders we may offer or discontinue in the future. If applicable to the rider/questionnaire: The available state footnotes are bracketed, to allow for approval by those states in the future; on products where the Charitable Legacy Rider is available, those footnotes are bracketed to allow us to remove them if, in the future, the Charitable Legacy Rider is not available. We will not offer any new optional benefit rider without State Department of Insurance (or IIPRC, if applicable in the future) approval.

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Form Number	Form Description
AXA-AIUL-2011	Flexible Premium Indexed Universal Life Insurance Questionnaire

1. **Marketing Name(s):** The marketing name(s) of each product is bracketed to allow for future changes. We will not offer any new product without State Department of Insurance (or IIPRC, if applicable in the future) approval.

2. **Optional Benefits/Riders (and footnotes):** We have bracketed optional benefits to allow for optional benefit riders we may offer or discontinue in the future. The Charitable Organization footnotes are bracketed to allow us to remove them if, in the future, the Charitable Legacy Rider is not available. We will not offer any new optional benefit rider without State Department of Insurance (or IIPRC, if applicable in the future) approval.

3. **Instructional Notes (Premium Allocation and Segment Maturity Reallocation):** The current Instructional Notes are shown on the form. These sections are bracketed to allow for any changes, as we intend to update the instructional notes as necessary.

4. **Indexed Options:** The current Indexed Options are shown on the form. These sections are bracketed to allow for any changes. These sections may vary as we change, add or delete any indexed options that we make available by product.

5. **Definition of Key Terms:** We reserve the right to change these definitions to reflect the terms used in any Indexed Universal Life-type policies that we offer. We also reserve the right to change any disclosures statements required by the indices that we offer.

Form Numbers	Form Description
AXA-COIL-2011	Flexible Premium Variable Universal Life Insurance Questionnaire
AXA-SIL-2011 (PRF)	Survivorship Variable Universal Life Insurance Questionnaire

1. **Marketing Name(s):** The marketing name(s) of each product is bracketed to allow for future changes. We will not offer any new product without State Department of Insurance (or IIPRC, if applicable in the future) approval.

2. **Optional Benefits/Riders:** We have bracketed optional benefits to allow for optional benefit riders we may offer or discontinue in the future. We will not offer any new optional benefit rider without State Department of Insurance (or IIPRC, if applicable in the future) approval.

3. **Customer Service Phone Number:** We have bracketed our Customer Service Phone Number to allow for future changes. We will notify current customers if the number changes.

4. **Investment Options:** This section may vary as we change, add or delete investment funds, including any indexed-linked investment funds, that we make available. This section also includes the investment options footnotes, which may change if the funds and/or optional benefits change.

5. **Automatic Transfer Service and Asset Rebalancing Service:** These sections are bracketed to allow for any changes by product type.

Form Numbers	Form Description
AXA-ILOpt-2011 (PRF)	Variable Universal Life Insurance Questionnaire
AXA-ILLeg-2011 (PRF)	Variable Universal Life Insurance Questionnaire

1. **Marketing Name(s):** The marketing name(s) of each product is bracketed to allow for future changes. We will not offer any new product without State Department of Insurance (or IIPRC, if applicable in the future) approval.

2. **Optional Benefits/Riders (and footnotes):** We have bracketed optional benefits to allow for optional benefit riders we may offer or discontinue in the future. The available state footnotes are also bracketed, to allow for approval by those states in the future; the Charitable Organization footnotes are bracketed to allow us to remove them if, in the future, the Charitable Legacy Rider is not available. We will not offer any new optional benefit rider without State Department of Insurance (or IIPRC, if applicable in the future) approval.

3. **Investment Options:** This section may vary as we change, add or delete investment funds, including any indexed-linked investment funds, that we make available. This section also includes the investment options footnotes, which may change if the funds and/or optional benefits change.

4. **Allocations if the Market Stabilizer Option is Elected:** We have bracketed this section to allow us to delete or make changes to the market stabilizer investment option. The Growth Cap Rate high range, currently shown as 10%, is bracketed may be changed to a percentage from 8% to 20%.

5. **Transfers from the Variable Investment Options to Supplement the Unloaned Guaranteed Interest Account (GIA):** We have bracketed this section to allow us to delete or make changes to the market stabilizer investment option.

6. **Segment Maturity Allocation:** We have bracketed this section to allow us to delete or make changes to the market stabilizer investment option.

7. **Customer Service Phone Number:** We have bracketed our Customer Service Phone Number to allow for future changes. We will notify current customers if the number changes.

8. **Automatic Transfer Service and Asset Rebalancing Service:** These sections are bracketed to allow for any changes by product type.

Form Number	Form Description
AXA-LTC-2011	Long-Term Care Services Rider Questionnaire

1. **Benefit Percentages:** We have bracketed the benefit percentages, as we reserve the right to increase or decrease the percentages shown, or we may include or exclude instructional notations pertaining to the issue age and product availability.

2. **Default Benefit Percentage:** We have bracketed the default benefit percentage, as we reserve the right increase or decrease the initial face amounts as described in this section.

Form Number	Form Description
AXA-FIN-2011	Financial Questionnaire

1. **Age and Amount Limitations:** We have bracketed age and amount of insurance limitations, as we reserve the right to change them in the future to allow for changes to underwriting requirements.

Form Number	Form Description
AXA-TCONV-2011	Term Conversion Application

1. **Company Address:** We have bracketed the Home Office address, as it may change in the future.

2. **Product Information (page 3):** We have bracketed the list of Product Information questionnaires to account for future changes in our portfolio. We will always get State Department of Insurance (or IIPRC, if applicable in the future) approval for the product before we offer it to the public.